Synergy Physical Therapy

39 CARLO RIVE

NORTHAMPTON MA 01060 p (413) 727-3315 f (413) 727-3316

SYNERGYPT413@GMAIL.COM

WORKERS COMPENSATION VERIFICATION

Patient Name: _____ Account No. _____

Date of Service: _____

Employer: _____ Telephone: _____

Address: _____ Fax : _____

_____

Type of Injury: _____

Date of Injury: _____

TO BE COMPLETED BY EMPLOYER

Should this visit be paid as a Workers Compensation claim? □ Yes □No

Please send bill to employer named above for payment □ Yes □ No

Please send bill to employer's workers compensation carrier:

Carrier Name: _____

Address: _____

Claim No. _____ Attention: _____

Phone: _____ Fax: _____

Adjustor: _____

EMPLOYER PLEASE NOTE

This form must be completed and returned to us. If we do not receive a response, the patient will be billed directly for payment of the services rendered.

Although a third party carrier may be billed for payment of the services rendered, by verifying the above as a Workers Compensation claim, **the above employer understands that they are ultimately responsible for payment of the services rendered** and that the employer will receive directly all billings and correspondence.

Questions? Please call us at (413) 727-3315

PLEASE FAX COMPLETED & SIGNED FORM TO (413) 727-3316