



## WORKER'S COMPENSATION AUTHORIZATION

I, \_\_\_\_\_, have been injured in an accident at my place of employment. I accept responsibility for any portion on my bill that may be rejected by my employer for any reason.

The information I have given concerning the name, address and telephone number of my employer is, to the best of my knowledge, true and correct.

I authorize **RediCARE** to contact my employer to verify the status of my employment and the validity of the Workmen's Compensation claim.

Urinary Drug Screen \_\_\_ Yes \_\_\_ No

\_\_\_\_\_  
PATIENT

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

### COMMENTS

#### PRIMARY COVERAGE

#### MAILING ADDRESS

EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE NO. \_\_\_\_\_

\_\_\_\_\_  
CITY \_\_\_\_\_

COMPANY REP. \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TIME \_\_\_\_\_

#### INSTRUCTIONS:

Types of payment for work related injuries: **(Please initial payment options selected)**

1. Employer Pays the Bill in Full: If employer request not to file workers comp, the employer may pay for the visit in full using cash, check, or credit card at time of service. Cash discounted prices will be granted to bills paid at time of service. **If employer fails to pay for the visit, the patient is responsible for the bill.**  
Initial \_\_\_\_\_

2. Employer Files Workers Compensation Claim: We will verify with your employer a work worker comp claim has been filed and obtain that claim number. We will then file the visit to workers compensation claim. In the event that workers comp disputes the injury or refuses to pay within 120 days then the bill **will be the responsibility of the patient.**  
Initial \_\_\_\_\_

3. Self Pay: Employee pays their bill OUTSIDE of workers compensation. Once you elect to pay out of pocket we **CAN NOT** go back and change the visit to a workers compensation visit. We also **CAN NOT** file a work related injury to your regular insurance.  
Initial \_\_\_\_\_