WORKERS COMPENSATION

BELLINGHAM ADVANCED MEDICAL IMAGING

Patient First and Last Name: _____

Date of Birth: _____/_____/_____

Social Security Number: _____ - _____ - _____

Workers Compensation Organization: _____

Workers Compensation Address: _____

Street Address or P.O. Box

_____

City State Zip Code

Adjuster's First and Last Name: _____

Adjuster's Phone Number: (_____) _____ - _____

Claim Number: _____

Date of Injury: _____/_____/_____

Body Part(s) Injured: _____

Employer at Time of Injury: _____

Employer Human Resources Phone Number: (_____) _____ - _____

Assignment of Insurance Benefits

I understand that I am primarily responsible for payment of all charges and/or services rendered regardless of the status of my claim with the Washington State Department of Labor and Industries Division of Worker's Compensation. I also understand that it is my responsibility to provide all necessary information needed for billing to Bellingham Advanced Medical Imaging. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance and any other health plans, to Bellingham Advanced Medical Imaging. This assignment will remain in effect until revoked by me in writing; a photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges that are not paid by said insurance. I hereby authorize Bellingham Advanced Medical Imaging to release all information necessary to secure payment.

Patient Signature: _____ Date: _____/_____/_____

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