Family Care Associates of Effingham, S.C.

1106 N. Merchant St., P.O. Box 665
Effingham, Illinois 62401
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www.familycareassociates.com

Worker's Compensation

In order to ensure timely submission and payment of worker's compensation claims, we require all of the following information to be completed accurately. Failure to provide all of the necessary information may result in claim denials and ultimately patient financial responsibility. Please take time to complete this form before your visit to Family Care Associates.

Work Comp. Carrier
Carrier Name_____
Agent_____
Phone Number_____
Claim Number_____
Date of Injury/Illness_____
Billing Address_____
_____
_____

Employer Information
Employer Name_____
Contact_____
Phone Number_____
Employer Address_____
_____
_____

_____Send claims directly to the worker's compensation carrier listed above.
_____Send claims directly to my employer.

We will bill your employer or their worker's compensation carrier as instructed above. If the requested information is not completed, full payment will be required at the time of service. You will be responsible for any charges denied by the worker's compensation policy.

I attest that all of the information stated above is accurate and complete. I understand I may be responsible for any charges denied by the worker's compensation policy.

_____ _____
Print Signature

Date_____