METRO MRI CENTER LIMITED PARTNERSHIP
615 Valley View Drive Suite 102 – Moline, IL 61265
(309) 762-7227 FAX (309) 762-7293

Date_____

Patient #_____

WORKERS COMPENSATION FORM

Patient Name:_____ Birth Date:_____

Address:_____ Soc. Sec. #:_____

City:_____ State:_____ Zip:_____ Sex: M F Marital Status: M S W D

Home Phone:_____ Work Phone:_____ Employment Status: Full Part Retired None

EMPLOYERS INFORMATION

Date & Time of injury:_____ Last date of work:_____

Employer: Name:_____ Supervisor:_____

Employer's address:_____ Contact phone #_____

City:_____ State:_____ Zip:_____ Employers phone #:_____

WORKERS COMPENSATION CLAIM SUBMISSION INFORMATION

Workers Compensation Insurance Carrier_____ Policy #:_____

WC Carrier Address:_____ Claim #:_____

City:_____ State:_____ Zip:_____ WC Phone #:_____

Contact Person:_____ Phone # of Contact person:_____

CONSENT, AUTHORIZATION, RELEASE & ASSIGNMENT

1. I authorize Metro MRI Center Limited Partnership (Metro MRI) employees, physicians, and designees to perform the medical testing ordered by my provider, to administer treatment, medication, or any procedure deemed necessary in the care and management of my case, and to release the results of such tests to my provider.
2. I authorize Metro MRI staff to request previous x-rays/medical records from any facility necessary to complete testing.
3. I authorize Metro MRI to release any information necessary (including the diagnosis, type of exam, and test results) to the above named Workers Compensation claim to facilitate billing and reimbursement directly to Metro MRI and Advanced Radiology, S.C. (AR) – (interpreting radiology group) insurance benefits under which I am entitled.
4. I request that payment of insurance benefits (including Medicare, Medigap, Medicaid, or other insurance) made to me or on my behalf, be assigned to Metro MRI Center Limited Partnership (Metro MRI) and Advanced Radiology, S.C. (AR) for any services furnished to me by these providers. I authorize holders of medical information about me to release to Metro and AR, any information needed to determine these benefits or the benefits payable for related services.
5. I understand that should my insurance company not honor this assignment of benefits, I will immediately forward any insurance payment received for services rendered by Metro MRI or AR to the respective provider.
6. I understand that if my injury or condition is work related I must report it to my employer. All Workers Compensation claims are subject to verification and approval. If my claim is denied I understand that I am responsible for payment of all services provided by Metro MRI and AR including payment of co-payments, deductibles, and non-covered benefits. Metro MRI will not wait for any settlement resulting from litigation or appeals. Should the account be referred to a collection agency, I agree to pay all reasonable fees and collection expense.
7. I agree that a photocopy of this form may be used in lieu of the original.
8. I certify that the above information given by me (or my representative) regarding insurance coverage is true and correct.

_____ _____ _____

SIGNATURE OF PATIENT OR PERSON RESPONSIBLE | RELATIONSHIP TO PATIENT | DATE