Hand and Upper Extremity Rehab, LLC

Patient Insurance / Worker's Comp Information Form

PLEASE PRINT

Patient Name: _____ Date of Birth: _____

Indicate which insurance this form is for:		
❑ Worker's Compensation	❑ Auto Accident (Auto Insurance)	❑ Health Insurance

Is this injury related to:	**Date of Accident or Injury**
❑ Work	
❑ Auto Accident	
❑ Other, specify	

Primary Health Insurance Info			
Name of Insurance Plan/Company:		**Type of Plan:** ❑HMO ❑PPO ❑Medicare	
Insurance Plan/Company Address: ***(usually found on back of card)***			
Telephone Number ( )	**Policy Number**	**Group Number**	
Responsible Person (Policy Holder)	**Relationship to Patient**	**Social Security No**	
DOB of Responsible Person	**Employer of Responsible Person**		

Secondary Health Ins. Info			
Name of Insurance Plan/Company:		**Type of Plan:** ❑HMO ❑PPO ❑Medicare	
Insurance Plan/Company Address: ***(usually found on back of card)***			
Telephone Number ( )	**Policy Number**	**Group Number**	
Responsible Person (Policy Holder)	**Relationship to Patient**	**Social Security No**	
DOB of Responsible Person	**Employer of Responsible Person**		

Worker's Compensation and Litigation			
Name of Worker's Compensation Carrier		**Claim Number**	
Street Address and City		**State**	**Zip Code**
Attorney's Name of (if lawsuit is involved)		**Phone Number**	
		( )	
Street Address and City		**State**	**Zip Code**

THIS FORM MUST ACCOMPANY THE PATIENT REGISTRATION FORM
Please give the receptionist a copy of all insurance cards and photo identification