R.B. Kolachalam, MD PC
Worker's Compensation Form

(Please fill top portion of form out ONLY, including Employer Information)

Is your consultation visit today a result of an injury received or caused by work?

_______YES _______ NO

By checking yes, and filling out Employer Information below you are allowing R.B. Kolachalam, MD PC to obtain information from your employer regarding injury. Our office MUST have authorization for your visit from both your employer and your worker's compensation company. IF our office is unable to obtain authorization for your visit, you may either reschedule for when we are able to obtain authorization or; IF your employer denies authorization you will be billed under private insurance. Remember that an authorization is not always a guarantee of payment. If you choose to proceed with no authorization your private insurance will be billed and you will be responsible for any and all patient balances. Thank You.

Patient Signature: ____ Date: _____________

Employer Info:

Name of Employer:

____

Contact Person: ____________________

Phone: _____________________

Fax: _____________________

Worker's Comp Info:

Company Name:

____

Claims Adjuster: ______________________

Claim Number: _________________________

Address:

____

____

Phone: __________________________

Fax: __________________________

____

____

____

____