Place Patient Label Here

WORKMENS COMP / MOTOR VEHICLE ACCIDENT / OTHER LIABILITY INSURANCE FORM

Should you not have your insurance information at the time of treatment, please return this completed form to the clinic within **TEN BUSINESS DAYS**. All applicable fields must be filled out to ensure your claim can be properly filed. **FAILURE TO PROVIDE THIS INFORMATION WILL RESULT IN YOUR SERVICES BEING BILLED DIRECTLY TO YOU.** Should you end up being billed directly, you may still provide this information to Associated Physicians for claims to be filed on your behalf.

Information May Be Provided to Associated Physicians Billing Department By:

Phone:
608-442-7797

Mail:
Associated Physicians
Attn: Billing
4410 Regent St
Madison, WI 53705

Email:
securebusoff@apmadison.com

You may also return this form to the Associated Physicians clinic front desk staff.

Patient Information

Patient Name: ____
Last First M.I.

Birth Date: ______________________

Address: ____

____

Accident Information

Type of Accident (check one): **Workers Compensation** ☐ **Motor Vehicle** ☐ **Other Liability** ☐

Date of Injury: ______________________ Time of Injury: ______________________

Place of Injury (i.e. Madison branch or breakroom): ______________________

Injury Sustained: ____

Dates of Missed Work (if applicable): ______________________

MORE INFORMATION ON BACK →

INITIAL TREATING DOCTOR INFORMATION
(LEAVE BLANK IF ASSOCIATED PHYSICIANS)

Doctor Name: ______________________ Facility Name: ______________________

Date Seen (if different than date of injury): __________ Facility Phone: ______________________

Facility Address: ____

EMPLOYER INFORMATION
(LEAVE BLANK IF ACCIDENT IS NOT WORKERS COMPENSATION)

Employer Name: ______________________ Employer Contact: ______________________

Employer Phone: ______________________ Employer Fax: ______________________

Employer Address: ____

For Physical Therapy appointments, please provide a copy of your job description to your therapist, so we can better treat your needs.

INSURANCE INFORMATION

Insurance Company: ______________________

Contact Name (not the same as employer contact): ______________________

Insurance Phone Number: ______________________ Insurance Fax Number: ______________________

Claim Number: ____

Claims Address: ____

____

SIGNATURES

By signing this form, I hereby authorize Associated Physicians to communicate with my employer regarding this injury, for the purposes of payment. I understand that this may include sharing information regarding treatment.

Patient/Guardian Signature: ______________________ Date: __________

Name/Relationship to Patient: ____