WORKERS COMPENSATION

NorthStar RADIOLOGY

Patient First & Last Name: _____

Date of Birth: _____/_____/_____

Social Security Number: _____ - _____ - _____

Workers Compensation Organization: _____

Workers Compensation Address: _____
Street Address or P.O. Box

_____
City State Zip Code

Adjuster's First & Last Name: _____

Adjuster's Phone Number: (_____) _____ - _____

Claim Number: _____

Date of Injury: _____/_____/_____

Body Part(s) Injured: _____

Employer at Time of Injury: _____

Employer Human Resources Phone Number: (_____) _____ - _____

Assignment of Insurance Benefits:
I understand that I am primarily responsible for payment of all charges and/or services rendered regardless of the status of my claim with the Alaska Department of Labor and Workforce Development Division of Worker's Compensation. I also understand that it is my responsibility to provide all necessary information needed for billing to North Star Radiology. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance and any other health plans, to North Star Radiology. This assignment will remain in effect until revoked by me in writing; a photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges that are not paid by said insurance. I hereby authorize North Star Radiology to release all information necessary to secure payment.

Patient Signature: _____ **Date**: _____/_____/_____

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