Family Care
ASSOCIATES
www.familycareassociates.com
1106 N Merchant Street
P.O.Box 665
Effingham, IL 62401
Ph: 217-342-7000 Fax: 217-342-7002

Worker's Compensation

In order to ensure timely submission and payment of worker's compensation claims, we require all of the following information to be completed accurately. Failure to provide all of the necessary information may result in claim denials and ultimately patient financial responsibility. Please take time to complete this form before your visit to Family Care Associates.

Work Compensation Carrier

Carrier Name _____
Agent _____
Phone Number _____
Claim Number _____
Date of Injury/Illness _____
Billing Address of Carrier _____
_____
_____

Employer Information

Employer Name _____
Contact Name _____
Phone Number _____
Employer Address _____
_____
_____

☐ Send claims directly to the worker's compensation carrier listed above.
☐ Send claims directly to my employer.

We will bill your employer or their worker's compensation carrier as instructed above. If the requested information is not completed, full payment will be required at the time of service. You will be responsible for any charges denied by the worker's compensation policy.

I attest that all of the information stated above is accurate and complete. I understand I may be responsible for any charges denied by the worker's compensation policy.

_____ _____
Print Signature

_____
Date