



Associated Plastic Surgeons & Consultants, P.C.

Cosmetic & Reconstructive Plastic Surgery

www.associatedplasticsurgeons.com

864 West Jericho Turnpike

West Hills, NY 11743

631-423-1000

Workers' Compensation Information

The following information is required to submit a claim for Workers' Compensation benefits on your behalf.

Patient's Name _____

Social Security Number _____

Address _____

City, State, Zip _____

Telephone _____

Employer's Name _____

Address _____

City, State, Zip _____

Telephone _____

Workers' Compensation _____

Insurance Company _____

Address _____

City, State Zip _____

WCB Case Number _____

Carrier Case Number _____

Date & Time of Injury _____

City & State where injury _____

occurred _____

Describe how injury occurred:

I certify the information contained above is correct to the best of my knowledge. In the event the policy above stated is not in effect, canceled or otherwise not valid, I note that I personally will be held responsible for payment. In addition, in the event this account becomes delinquent, I am aware that I will be held fully responsible for full payment as well as legal fees incurred in the collection of a delinquent account.

Patient's Signature _____