

## WORKERS COMPENSATION ASSIGNMENT OF BENEFIT FORM

AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE OF CLAIMANT TO PROSECUTE OR IF COMPENSATION CLAIM IS DISALLOWED.

| WCB CASE NO.          | CARRIER CASE NO.                          | DATE OF INJURY AND TIME | ADDRESS WHERE INJURY OCCURRED | INJURED PERSON'S SOC. SEC. NO. |
|-----------------------|---|-------------------------|-------------------------------|--------------------------------|
|                       |   |                         |                               |                                |
| <b>INJURED PERSON</b> | FIRST NAME    MIDDLE INITIAL    LAST NAME |                         | ADDRESS:                      | TELEPHONE NO.                  |
| <b>EMPLOYER</b>       |   |                         | ADDRESS:                      |                                |
| <b>INSURANCE</b>      |   |                         | ADDRESS:                      |                                |
| <b>REFERRING MD</b>   |   |                         | ADDRESS:                      |                                |

\*If treatment was rendered under the Volunteer Firefighter's Benefit Law show as EMPLOYER the liable political subdivision and enter "X" here: \_\_\_\_\_.

In the event I fail to prosecute the claim for Workers Compensation for this illness or condition or it is determined by the Workers Compensation Board that the illness or condition is not a result of a compensable Workers Compensation case, I \_\_\_\_\_, hereby agree to pay **Life Physical Therapy & Wellness, P.C.**, for usual and customary fees for services rendered to the above named claimant in the identified case.

**PRIMARY PRIVATE INSURANCE INFORMATION: (Provide in the event WC Claim is denied)**

**Insurance Company's Name:** \_\_\_\_\_ **Tel#** \_\_\_\_\_

**Insurance Company's Address:** \_\_\_\_\_

**Name of Insured:** \_\_\_\_\_ **Your Relation to Insured:** \_\_\_\_\_

**Insured's Employer:** \_\_\_\_\_

**Insured's Social Security#** \_\_\_\_\_ **Policy/Group#** \_\_\_\_\_

**Signature of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_