Workers' Compensation Accident/ Injury Insurance Information Form

To complete this form electronically, please go to www.essentiahealth.org
Using the drop-downs under "How can I help you?" select: "I am a Patient" and "I'd like to Pay my Bill". Under "Third Party Billing Forms" select the quick link to access this document.
After completing the document online, please return form within *7 days* to: AccidentInjuryInsInfo@EssentiaHealth.org

Patient Information

Name:_____
Phone number:_____
Date of Birth:_____
Last 4 of Social Security Number: _____
Date Of Service: _____
Medical Record #:_____
Guarantor #:_____

Date of Injury: _____
Type of Injury/ Body Part Injured (Be Specific):_____
State Accident Occurred In:☐MN☐WI ☐ND☐MI
☐Other (Please Specify What State):_____

****To Ensure proper processing of the charges related to this injury, please check one or more of the applicable boxes listed below****

☐I **did** have a Workers' Comp injury (Complete Section A)
☐I **did not** have a Workers' Comp injury (Complete Section B)
☐I am **self-employed** & do not have a workers' compensation insurance. (Complete Section B)

☐This worker's compensation claim is pending with my attorney. (Complete Section B)
Attorney's Name: _____
Attorney's Number: _____
☐This is not a work-related injury. (Complete Section B)
☐**Other** (Please Specify):_____

Section A: Workers' Compensation Insurance to be billed for this accident: (Obtain Information from Employer)

Insurance Company Name:_____
Address:_____City:_____
State:_____ Zip:_____
Phone:_____
Claim Number: _____

Policy Number: _____
Claim Adjuster's Name: _____
Claim Adjuster's Fax:_____
Claim Adjuster's Phone: _____

Employment Information at the Time of Injury:

Employer's Name:_____
Address:_____

City: _____
State: _____ Zip:_____
Phone: _____

Section B: Primary Health Insurance Billing Information

Insurance Company: _____
Claim Mailing Address:_____
City: _____ State: _____
Zip: _____ Phone: _____
Effective Date of Policy: _____

Name of Subscriber: _____
Relationship to Patient: _____
Policy ID Number: _____
Group Number: _____

Secondary Health Insurance Billing Information:

Insurance Company: _____
Claim Mailing Address: _____
City:_____State:_____
Zip: _____ Phone:_____
Effective Date of Policy: _____

Name of Subscriber: _____
Relationship to Patient: _____
Policy ID Number: _____
Group Number:_____

I hereby authorize Essentia Health to release information and medical records to the Workers' Compensation insurance company listed for the payment of all related medical services regarding the Date of Injury above. Should Worker's Compensation deny payment for the claims, we will submit the denial and a new bill to your health insurance carrier.

Print Name:_____ **Signature:**_____
Phone:_____**Date:**_____

***Form may also be mailed/Faxed to the following:** Essentia Health
1702 South University Drive
Fargo, ND 58103 Fax: 701-364-8921

Essentia Health