Advanced
MEDICAL IMAGING
7601 Pioneers Blvd., Lincoln, NE 68506
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Workers Compensation Claim Information

Patient Name:	Date of Birth:
Work Comp Insurance Carrier:	WC Claim #:
Claims Mailing Address:	
Adjustor:	Phone Number:
Employer (at time of injury)	Date of Injury

Prior to services, Advanced Medical Imaging will confirm that authorization has been obtained regarding your claim.

If your Workers Compensation denies responsibility for coverage, we will pursue payment through your commercial health insurance policy. If you do not provide us with the necessary health insurance information or do not have health insurance, it is our policy to consider you a "self-pay" patient.

We will not bill your health insurance unless the above-mentioned workers compensation carrier denies responsibility. If your health insurance is billed, you will be responsible for any deductibles, coinsurance, or copays.

Commercial Health Insurance Information

Insurance Company:	Member/Policy Number: _____
	Group #: _____ Employer: _____
Address: Phone:	Subscriber Name: _____
	Subscriber Date of Birth: _____

☐ **I request Advanced Medical Imaging to refrain from submitting any claims or information to my health insurance company related to the service(s), and I agree to assume all payment obligations for such service without regard to the health coverage I have available to me through the above listed insurance company. I understand I will be responsible for full billed charges.**

☐ **I give permission to Advanced Medical Imaging to file to my health insurance in the event the 3rd party carrier does not remit payment in 45 days. I understand that I will be held personally responsible for cost of service(s) provided and any deductibles, coinsurance, or copays from my health insurance company will become my responsibility.**

I certify that, to the best of my knowledge, the provided information above is true and accurate.

Patient Signature: _____ Date: _____