EAR, NOSE & THROAT ASSOCIATES OF NASSAU COUNTY, P.C.

2870 Hempstead Turnpike, Suite 203, Levittown, NY 11756 Telephone: (516) 731-6644 Fax: (516) 731-8746
165 North Village Ave, Suite 117, Rockville Centre, N.Y., 11570 Telephone: (516) 764-1055 Fax: (516) 764-1062
333 Glen Head Road, Suite 110, Old Brookville, N.Y. 11545 Telephone: (516) 671-5511 Fax: (516) 671-5210

WORKER'S COMPENSATION INFORMATION

Claimant Name: ______________________________

Date of Birth: ______________ **Social Security Number:** ______________

Claimant Address: ______________________________

Date of Injury: ______________________________

Employer: ______________________________

Nature of Injury or Illness: ______________________________

WORKER'S COMPENSATION INSURANCE INFORMATION

Insurance Carrier: ______________________________

Carrier Address: ______________________________

Carrier Phone Number: ______________________________

WCB Case Number: ______________________________

Carrier Case Number: ______________________________

Agent Name & Phone & Fax: ______________________________

In the event I fail to prosecute the claim for Worker's Compensation for this illness or condition or it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Worker's Compensation case, I hereby agree to pay my health care provider (s) their usual and customary fees for services rendered to the above names claimed in the above identified case.

Card Type	
Cardholder Name	
Card Number	
Expiration Date (mm/yy)	
Cardholder Zip Code	

Signature: ______________________________ **Date:** ______________