NEUROSURGICAL ASSOCIATES OF CNY, LLP
Workers' Compensation
Information Verification Form

The Workers' Compensation Board now requires that we verify the following information for each visit. We appreciate you taking the a few moments to complete this form so that we can process your claim properly.

PATIENT NAME: _____ **DOB: _____**

DATE OF VISIT: _____ **SOCIAL SECURITY#:_____**

DATE OF INJURY: _____

CARRIER NAME: _____

On the date of the injury/ illness:

1) **What was your job title?**

_____

2) **What were your usual work activities?**

_____

3) **Who was your employer?**

_____

4) **Describe how the accident happened:**

_____

_____

5) Are you currently working? ___ YES ___ NO

6) What is your WCB Case #: _____

7) What is your Carrier Case #: _____

8) Compenstation case adjustor: Name _____
Phone#:_____
Fax#:_____

Patient Signature: _____ **Date: _____**