

Tier Orthopedic Associates, P.C.
100 Plaza Drive
Vestal, NY 13850
607-798-9356

To correctly bill and supply your WC (workman's compensation) or NF (no-fault) insurance with the correct information we will need the following information from you. Please provide this information to our office within 48 hours of your visit.

You may also fax this form to 607-770-6887.

Patient Name: _____

Employer Name: _____
(at time of the injury)

Address: _____

Date of Injury: _____ Job Title: _____

Brief Description of how the injury occurred: _____

WC or NF Insurance Carrier: _____

Address: _____

Claim# _____ WCB# _____

Are you currently working? YES or NO

Have you filed a claim with your employer? YES or NO
(if workman's compensation)

If it is deemed that this is not a work related or no-fault injury, you or your private insurance will be responsible for any balance.

Patient Signature: _____

Date: _____