



WORKER'S COMPENSATION INFORMATION

NAME: _____ SOCIAL SECURITY #: _____

DID YOU FILE AN ACCIDENT REPORT WITH YOUR EMPLOYER? YES NO

EMPLOYER'S INFORMATION:

NAME/ADDRESS:

EMPLOYER'S TELEPHONE #: _____ CONTACT PERSON: _____

JOB TITLE: _____ DATE & TIME OF INJURY: _____

*** PLEASE STATE IN YOUR OWN WORDS WHAT YOU INJURED, HOW THE ACCIDENT/INJURY OCCURRED, WHAT YOU WERE DOING AT THE TIME OF INJURY (TYPE OF WORK, WORK AREA, TYPE OF EQUIPMENT INVOLVED, ETC,...) INCLUDE ALL THE BODY PARTS THAT WERE AFFECTED BY THIS INJURY :**

HAVE YOU HAD ANY PRIOR INJURIES TO THESE AFFECTED AREAS? YES NO

*** IF YES, PLEASE DESCRIBE:**

WORKER'S COMPENSATION INSURANCE CARRIER'S INFORMATION:

NAME/ADDRESS:

INS. CARRIER'S TELEPHONE #: _____ CONTACT PERSON: _____

CARRIER CASE #: _____ WORKER'S COMP. BOARD # (8 DIGITS): _____

PLEASE READ AND CHECK THE BOXES BELOW, IN AGREEMENT, BEFORE SIGNING.

- I DECLARE THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.
- I AGREE TO PAY FOR SERVICES PROVIDED IF COVERAGE IS DENIED BY BOTH WORKER'S COMPENSATION AND MY PRIMARY INSURANCE COMPANY.
- I AUTHORIZE FAMILY MEDICINE OF MALTA TO RELEASE INFORMATION REGARDING THIS CASE TO THE ABOVE WORKER'S COMPENSATION CARRIER AND CASE MANAGERS AFFILIATED WITH THIS CARRIER, AS WELL AS MY, PRIMARY INSURANCE COMPANY IF COVERAGE IS DENIED BY WORKER'S COMPENSATION.

SIGNATURE: _____ DATE: _____



NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)		CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.
CLAIMANT	NAME			ADDRESS	APT. NO.
EMPLOYER					
INSURANCE CARRIER					

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature _____ Date _____

Provider's Name and Address _____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.