

## CoxHealth Springfield, MO Workers' Compensation

Patient Sticker

## REQUEST FOR COVERAGE & AUTHORIZATION TO DISCLOSE INFORMATION

In order for the hospital, physician, or other healthcare provider to register a patient for service with workers' compensation payor as a guarantor, the patient, or his/her supervisor must so state during registration. If the supervisor is not accompanying the patient, written communication from the company will be required. Please forward written verification to CoxHealth: Attention: Patient Financial Services, 1423 N. Jefferson Ave. Springfield, MO 658020. Telephone: 417/269-3117, Fax: 417/269-3796.

If you register as work comp and your employer denies the work comp claim, you and/or your insurance company will be billed for services provided.

	Employer	Insurance Company
Company Name		
Address		
City, State, & Zip		
Contact Person:		
Phone Number:		
Employee's Name:		
mployer's Signat	ure:	Title:
	Authorization to	Disclose Information
, the undersigned a	authorize and request CoxHealth to	release my complete medical record pertaining to the assident that
ccurred on	affecting the body par	ts to my employer by workers' compensation claim. The medical records, which may be
and/or their Insuran	ce Company in order to process n	ny workers' compensation claim. The medical records, which may be
eleased according	to this authorization, are limited to	medical treatment for the injury suffered on the date of accident
sted above. ONLY	records that relate to the injury lis	ted above, as to the type of injury and the part of the body injured,
nou ha included MA	adical reserved from L. f	, , , , , , , , , , , , , , , , , , , ,
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Original: HIM Imaging

Photocopy: Patient

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