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: ____________________

First Original Date of Injury: ____________________

Nature of Injury: ____________________

Claim Number: ____________________

Employer's Signature: ____________________ **Title:** ____________________

Authorization to Disclose Information

I, the undersigned authorize and request CoxHealth to release my complete medical record pertaining to the accident that occurred on ______________ affecting the body parts ______________________ to my employer and/or their Insurance Company in order to process my workers' compensation claim. The medical records, which may be released according to this authorization, are limited to medical treatment for the injury suffered on the date of accident listed above. ONLY records that relate to the injury listed above, as to the type of injury and the part of the body injured, may be included. Medical records from before the date of accident or medical records after the date of accident, which do not relate to THIS injury, may not be released pursuant to this authorization. I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I agree to its release.

☐ I am presenting for a lab test only, which has been requested by my employer. I understand that the results will be sent to my employer. I do not want a medical screening exam to be performed by the ED Physician.

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 3801 S National Ave. Springfield, MO 65807.

Re-disclosure

I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure.

Certification

I understand that I do not have to sign authorization, and my treatment or payment for services will not be denied if I do not sign this form. I can inspect or copy the protected health information to be used or disclosed.

I authorize CoxHealth to use and disclose the protected health information specified above.

Patient's Signature: ____________________ **Date:** ___/___/___ Witness: ____________________
(Patient, parent if minor child, or legal guardian)

CPS-5292 7-01 Rev.7-12 Original: HIM Imaging Photocopy: Patient