ADIRONDACK RADIOLOGY

Date: _____ **Account #**_____

*****PLEASE BE AWARE WE HAVE 90 DAYS TO FILE YOUR CLAIM. PLEASE RETURN THIS INFORMATION AS SOON AS POSSIBLE. THANK YOU*****

Dear _____

The following information is needed from you in order to submit your bill for payment under worker's compensation. Please complete the information below and return it as soon as possible to avoid a delay in submitting your claim and becoming financially responsible for the full bill. Information can be obtained from your insurance carrier. Please notify our office in case no claim has been filed with your employer and we need to submit charges to your medical provider. You may call our billing office with the information at (518) 793-6571.

Employer Name: _____

Employer Phone: _____

Accident Date: _____Injured Body Part: _____

Compensation Carrier: _____

Carrier Address: _____

Carrier Phone: _____

Carrier Claim Number: _____

Adjustor Name: _____ Phone number: _____

Thank you for your cooperation.

Sincerely,

Adirondack Radiology Associates
P.O. Box 985
Glens Falls, NY 12801
Billing Phone (518) 793-6571
Billing Fax: 518-761-4674