Associated Plastic Surgeons & Consultants, P.C.
Cosmetic & Reconstructive Plastic Surgery
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West Hills, NY 11743
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Workers' Compensation Information

The following information is required to submit a claim for Workers' Compensation benefits on your behalf.

Patient's Name ______________________________

Social Security Number ______________________________

Address ______________________________

City, State, Zip ______________________________

Telephone ______________________________

Employer's Name ______________________________

Address ______________________________

City, State, Zip ______________________________

Telephone ______________________________

Workers' Compensation
Insurance Company ______________________________

Address ______________________________

City, State Zip ______________________________

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WCB Case Number ______________________________

Carrier Case Number ______________________________

Date & Time of Injury ______________________________

City & State where injury
occurred ______________________________

Describe how injury occurred:

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I certify the information contained above is correct to the best of my knowledge. In the event the policy above stated is not in effect, canceled or otherwise not valid, I note that I personally will be held responsible for payment. In addition, in the event this account becomes delinquent, I am aware that I will be held fully responsible for full payment as well as legal fees incurred in the collection of a delinquent account.

Patient's Signature ______________________________