ALBANY MED Health System

Workers' Compensation Request for Information

Please provide the following information in order for us to bill your visit to Workers' Compensation

Please provide the information below:

Name of Employee:	
Telephone Number:	
Certification or Social Security Number:	
Claim/File Number:	
Date of Injury: (Month, Day, Year)	
Body Part Injured:	

Employer Name:	
Street Address:	
City, State, ZIP:	
Phone Number:	
Name of Insurance:	
Adjuster Name:	
Adjuster Phone Number:	
Please include any additional insurance(s) information available for submission on remaining balances:	