



MAPLE CREST IMAGING CENTER
WORK COMPENSATION VERIFICATION
840 W Kansas Avenue Liberty, MO 64068
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Phone: (816) 781-9797 Fax: (816) 781-9793

Date

Patient Information

Patient Name Phone Number Social Security #

Address City State Zip Code

Claim Information

Date of Injury Claim Employer Name Employer Phone

Employer Address City State Zip Code

Claim Address City State Zip Code

Authorization

I certify that the information given by me in regard to worker's compensation is correct. To the best of my knowledge, the claim is active at the time of this signature.

I, _____ give my permission for my charges to be submitted to my private medical insurance carrier if the worker's compensation claim is denied or found to be invalid. I also understand that I may be responsible for payment of services not covered by my private medical insurance.

Patient Signature

Date