AGREEMENT TO PAY COSTS IN THE EVENT OF FAILURE TO PROSECUTE OR IF COMPENSATION CLAIM IS DISALLOWED

** FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY WILL DELAY PAYMENT FORM THE WORKERS COMPENSATION BOARD**

WCB CASE # (IF KNOWN):		
CARRIER CASE # (IF KNOWN):		
DATE OF INJURY:		
HOW DID INJURY OCCUR?:		
CITY WHERE INJURY OCCURRED:		
IS CLAIMANT WORKING:	☐ YES	☐ NO

CLAIMANT NAME:	
CLAIMANT ADDRESS:	
CLAIMANT DOB:	
CLAIMANT SS#:	
CLAIMANT EMPLOYER:	
EMPLOYER ADDRESS:	
EMPLOYER PHONE #:	
EMPLOYER INSURANCE CARRIER: (THIS IS NOT YOUR HEALTH INSURANCE COMPANY!)	
INSURANCE CARRIER ADDRESS:	
INSURANCE CARRIER PHONE #:	
CASE MANAGER NAME (IF APPLICABLE)	

IN THE EVENT I FAIL TO PROSECUTE THE CLAIM FOR WORKERS' COMPENSATION FOR THIS ILLNESS OR CONDITION, OR IT IS DETERMINED BY THE WORKER' COMPENSATION BOARD THAT THE ILLNESS OR CONDITION IS NOT THE RESULT OF TA COMPASSABLE WORKER' COMPENSATION CASE,

I _____, HEREBY AGREE TO PAY DR. _____

OF (ADDRESS)_____

HIS USUAL AND CUSTOMARY FEES FOR SERVICES RENDERED TO THE ABOVE IDENTIFIED CASE.

CLAIMANT SIGNATURE: _____ DATED:_____

IF SIGNED BY OTHER THAN CLAIMANT, PRINT BELOW NAME, ADDRESS AND RELATIONSHIP TO CLAIMANT

NAME: _____

ADDRESS: _____

RELATIONSHIP: _____

**** FORM MUST BE COMPLETELY FILLED OUT FOR CORRECT PAYMENT****