SPINE AND SCOLIOSIS CENTER
OF STONY BROOK ORTHOPAEDIC ASSOCIATES

STONY BROOK UNIVERSITY Physicians

BILLING INTAKE SHEET

Patient's Name: ______________________________ MRN: _______________

HEALTH INSURANCE

Insurance Company: ____
Policy/ ID#: ____
Authorization# (if applicable): _____________________________________
Number of visits:__________
Effective Date: ___________________ Termination Date:________________

WORKER'S COMPENSATION

Employer at the Time of the Accident: __________________________________
Employer Name: ____
Employer Address: ____
____
Employer Phone#: ____
Social Security#: ______________________
WC Insurance Name: ____
Insurance Address: ____
____
Date of accident: ______________________
WCB#: _______________________________
Carrier Claim #:________________________

NO FAULT

Policy Holder: ____
Policy Number: ____
Date of Accident: ____
Claim/ File Accident: ____
NF Insurance Name: ____
Insurance Address: ____
____
Insurance Carrier Phone#: _____________________

Clinical Office:
181 N. Belle Mead Road
East Setauket, NY 11733
631.444.BACK (2225)

Administrative Offices:
Stony Brook University Medical Center
HSC, Level 18
Stony Brook, NY 11794-8181
631.444.7830