



**ROCK CREEK IMAGING**  
**WORK COMPENSATION VERIFICATION**  
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Phone: (913) 351-4674 Fax: (913) 351-3329

\_\_\_\_\_  
Date

**Patient Information**

\_\_\_\_\_  
Patient Name Phone Numb 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