OLD GREENWICH MEDICAL GROUP
Burton Rubin, M.D.
Jayne Pincus, M.D. Ph.D
Rebecca Warkol, M.D. LLC
Melanie Kelton, M.D.

CLAIM INFORMATION REQUEST

Patient Name: ______________________________ DOB: _____________________

Hello-

The above-named patient was seen in our office on: ___________________

I attempted to call you for this information on: _____________________

Please provide requested information via FAX to: 203-637-5408. Please contact Karyna with any questions.

I authorize and request you to release records to: Old Greenwich Medical Group, Billing Department

Please provide the following information for billing purposes:

1. Claim Number
2. Company name and claims billing address
3. Date of loss
4. State of incident
5. Injured body part
6. Adjuster's Name – Telephone number – Fax number
7. Is patient's condition related to employment?

ATTN: ______________________

Phone: ______________________

Fax: ________________________

8 West End Avenue • Old Greenwich, CT 06870 • Phone: 203-637-5406 • Fax: 203-637-5408 • www.oldgreenwichmedicalgroup.com