WCB Case #	Claim Admin Claim #	Date of Injury	Case Controverted
G3104710		08/20/2021	No

Case Established
No

Injury Description

Nature of Injury

Cause of Injury

Body Part(s)/Condition(s)

Employer

Employer Name
Luis Painting Corp.

Employer Address
34-66 110th Street
Queens, NY 11368 US

Insurer

Insurer Name
*** Carrier Undetermined ***

Insurer ID
W000004

Claim Administrator

Claim Admin Name
*** Carrier Undetermined ***

Claim Admin ID
W000004

Patient Information Form

LIMA, OLBERTO

Integrative Medical Services PC

Print Date:2022-08-18

PATIENT INFORMATION

PATIENT'S NAME LIMA, OLBERTO		**ACCT/CHART#** 2413656	
DOB 06/05/1976	**MARITAL** Single	**GENDER** Male	**SSN**
ADDRESS 8728 118TH STREET APT#2		**CITY** RICHMOND HILL	**STATE** NY **ZIP** 11418
HOME PHONE 203-694-2908	**WORK PHONE**	**MOBILE PHONE** 203-694-2908	
EMAIL		**RACE** Declined to Specify	**OCCUPATION**
EMPLOYED	**EMPLOYER**	**ADDRESS**	
ATTENDING PHYSICIAN Islam, Mohammad S		**REFERRAL PHYSICIAN**	

FAMILY INFORMATION

KIN'S NAME		**RELATIONSHIP**	
DOB	**PHONE**	**SSN**	
ADDRESS	**CITY**	**STATE**	**ZIP**

EMERGENCY CONTACT

NAME	**RELATIONSHIP**	**PHONE**	
ADDRESS	**CITY**	**STATE**	**ZIP**

INSURANCE INFORMATION

NF/WC

INSURANCE NYS WORKERS` COMPENSATION NO INS. UNIT		**CLAIMANT** LIMA, OLBERTO	
RELATIONSHIP Self	**CASE TYPE** Worker`s Comp	**CASE STATUS** Active	
INITIAL VISIT DATE 01/01/1900	**CASE STOP DATE** 01/01/1900		
CLAIM#	**POLICY#** G3104710		
REPRESENTING ATTORNEY VILLAMAR & MEWAFY PLLC VILLAMAR, JAMES	**PHONE(ATTORNEY)** 718-726-2400		
ADJUSTER NAME	**ADJUSTER NUMBER**		
D.O.A. 08/20/2021 00:00	**CASE RELEATED TO**	**EMPLOYER** LUIS PAINTING CORP	

Acknowledgement of HIPAA notice of privacy practices

I hereby acknowledge that I have fully reviewed and/or have received a complete copy of the HIPAA notice of privacy practices provided by the staff of this office.

Medicare / Medicaid Assignment of Benefits

I certify that the information given by me in applying for payment is correct.I authorize release of all records upon request.I request that payment of authorized benefits be made on my behalf.

Assignment of Insurance Benefit

I hereby authorize direct payment of medical benefits to **[Integrative Medical Services PC]** for services rendered by all medical providers in the corporation. I understand that I am financially responsible for any balance if my insurance is invalid.

DATE:

Claim Search

1. Enter either WCB Case # or Claim Administrator Claim #. The search uses exact values to locate a claim.

WCB Case #

G3104710

Must be eight characters in length. The first character may be any number or letter EXCEPT [B,C,E,I,O], the second character may be any number or letter EXCEPT [I,O], and the remaining six must be numbers.

Claim Admin Claim #

2. Enter only two of the below fields to search for this claim.

Date of Injury

08/20/2021

(MM/DD/YYYY). If exact date of injury/illness is not known, use other search criteria.

Last Four of SSN

Date of Birth

Patient Last Name

LIMA

Search for Claim

Clear Search

Search Results

Patient

Patient Name	Patient DOB	Patient SSN	Patient Gender
Olberto Lima	06/06/1976		M

Patient Address

8728 118th Street, Apt 2
Richmond Hill, NY 11418 US