



ORTHOPAEDIC MULTISPECIALTY NETWORK, INC

4760 Belpar Street NW * Canton, OH 44718 *
(330) 492-9200 * Fax (330) 492-5454

Name: _____

Birth Date: _____

Accident Date: _____

The following statement will serve as confirmation of subrogation:

I have/will contact my health insurance company _____
in reference to the above-indicated accident and have/will provide them with the information they
require in order to subrogate any and all related health claims. I hereby authorize OMNI
Orthopaedics to submit any and all claims for treatment rendered to me for this accident to the
above named health insurance carrier. I understand that I am still financially responsible and
liable for any co-pay, co-insurance, and/or deductible that my health insurance policy requires I
pay. In the event my insurance company denies payment due to lack of a valid subrogation
agreement, or for any other reason, I understand that I will be responsible for immediate payment
of the balance in full.

Signature: _____

Date: _____