Authorization for Workers Compensation

Patient Name: _____ DOB: _____

Address: _____

Patient Phone: _____

Patient email: _____

Employer: _____ Phone: _____

Appt Date & Time: _____ Doctor: _____

Facility: _____

Insurance Company Name: _____

Address: _____

Can we do in house MRI, if needed? _____

Can we do in house EMG/NCS? _____

Company used to schedule diagnostics & therapy: _____

Adjuster: _____

P: _____

F: _____

E: _____

NCM: _____

P: _____

F: _____

E: _____

Claim #: _____

Date of Injury: _____ State Jurisdiction: _____

Authorized Body Parts: _____

Type of Injury: _____

Has patient had **ANY** treatment? _____ Where? _____

Diagnostic type: _____ Diagnostic Facility: _____

Authorized By: _____ Phone: _____

Title: _____ Via (circle): Phone Email Fax

Initial: _____

Date: _____

Please have any medicals emailed to me at workerscomp@ortho-augusta.com.