Authorization for Workers Compensation

Patient Name: _____ DOB: _____ **Male** **Female**

Address: _____

Patient Phone: _____ Patient email: _____

Employer: _____

Employer protocol for how often patient must be seen: _____

Insurance Company Name: _____

Billing Address: _____

Does the patient need transportation: **YES** **NO** Interpreter? **YES** **NO**

WC company is responsible for setting up any transportation and interpreter needs.

Adjuster: _____ NCM: _____

P: _____ P: _____

F: _____ F: _____

E: _____ E: _____

Claim #: _____ Date of Injury: _____ State: _____

Authorized Body Part(s): _____

Laterality: **LEFT** **RIGHT** **BILATERAL** **(Please indicate for each if multiple body parts.)**

Type of Injury(circle): **Strain/Sprain** **Crush** **Fracture** **Laceration** **Amputation** **Tear/Rupture**

Other: _____ Mechanism of injury: _____

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

Diagnostic type(circle): X-RAY MRI CT EMG/NCS Diagnostic Facility: _____

Did you inform that the patient must bring imaging on a CD AND reports to appointment? _____

Authorized By: _____ Phone: _____ Title: _____

Appt Date & Time: _____ Physician: _____ Office: _____

Initial: _____

Date: _____

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