RALEIGH HAND CENTER
CARE OF THE HAND AND ARM

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WORKERS COMPENSATION REQUEST

In addition to your usual cover letter, it will greatly expedite our review and scheduling if you provide the following preliminary information. PLEASE NOTE**:** There will be a $100.00 charge in the event that an appointment is not canceled prior to 48 hours of the scheduled time or $150.00 if patient is also scheduled for a therapy evaluation. If the requested x-rays, MRIs, reports, etc. are not present at the time of the appointment, the appointment may be rescheduled at the doctor's discretion, and a $100.00 rescheduling fee will be assessed. Payment must be made prior to rescheduling.

Patient's Name:_____ Phone #:_____

Patient's Date of Birth:_____ Date of Injury:_____

Patient's Address _____

Employer Name & Address:_____

Diagnosis: _____ Current work status:_____

Brief outline of treatment to date:

Purpose for referral (i.e. IME, 2nd opinion, treat, PPD rating):_____

Adjuster:_____Phone #:_____ext._____Fax#_____

Case Manager: _____ Email: _____

Phone #:_____ ext._____ Fax #_____

Billing Information: Name & Address: _____

Claim# _____

Name of Company providing transportation / translation:_____

Please indicate if an initial therapy visit in our office (if required) is approved _____

Does therapy billing go through Align, Medrisk or other? Please indicate: _____

PLEASE INDICATE IF YOU ARE REQUESTING A SPECIFIC MD TO REVIEW THE NOTES:

_____