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WORKERS COMPENSATION REQUEST

Patient's Name: _____ Phone #: _____

Patient's Address: _____

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

Employer Name & Address: _____

Diagnosis: _____ Current work status: _____

Brief outline of treatment:

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

Adjuster: _____ Email: _____

Adjuster Phone #: _____ ext. _____ Fax# _____

Case Manager: _____ Email: _____

Case Manager Phone #: _____ ext. _____ Fax# _____

Billing Information: Name & Address: _____

Claim# _____

Name of Company providing transportation / translation: _____

Please indicate if an initial therapy visit in our office is approved (if requested by MD): _____

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

Please indicate if you are requesting a specific doctor to review the case: _____

PLEASE NOTE: There will be a \$100.00 charge if a missed appointment is not canceled prior to 48 hours of the scheduled time or \$150.00 if the patient is also scheduled for a therapy evaluation. If the requested studies (such as x-rays, MRI, nerve study reports, etc.) are not available at the time of the appointment, the appointment may be rescheduled at the doctor's discretion, and a \$100.00 fee will be assessed. Payment must be made prior to rescheduling an appointment.