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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 of Carrier & 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 $150.00 charge if a missed appointment is not canceled prior to 72 hours of the scheduled time or $200.00 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 $150.00 fee shall be assessed. Payment must be received prior to rescheduling a missed appointment.*