RALEIGH HAND TO SHOULDER CENTER

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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 Medrisk, OneCall or Spnet or direct bill to carrier? Please indicate: _____

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

PLEASE NOTE: *There will be a $200.00 charge if a missed appointment is not canceled prior to 72 hours of the scheduled time or $250.00 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 $200.00 fee shall be assessed. Payment must be received prior to rescheduling a missed appointment.*