erlanger
Neurosurgery and Spine

979 E. 3rd Street, Suite C-920
Chattanooga, TN 37403
Phone: 423-778-2233
Fax: 423-756-8265
Referral Fax: 423-321-1115

WORKERS COMP QUESTIONNAIRE / AUTHORIZATION SHEET

AUTHORIZED FOR MD: _____

Patient Name: _____

DOB: _____ **SS #:** _____

Referring Physician: _____ **NPI:** _____

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

Part of Body Disabled: _____ **Diagnosis:** _____

_____

Previous surgery relating to diagnosis: ☐ **No** ☐ **Yes – when:** _____

EMPLOYER: _____

Address: _____

ADJUSTER / CASE MANAGER – WILL BE REQUIRED TO SCHEDULE & ATTEND APPOINTMENTS

Name: _____ **Phone:** _____

Email: _____ **Fax:** _____

SEND OFFICE NOTES & TEST RESULTS

Attn: _____ **Phone:** _____

Email: _____ **Fax:** _____

MAIL CLAIMS

Company: _____ **Attn:** _____

Address: _____

Approved Facilities for MRI, X-Rays & Tests:

Company: _____ **Phone:** _____ **Fax:** _____

VISIT AUTHORIZATION - Evaluate and Treat: ☐ **Yes** ☐ **No** / **2nd Opinion:** ☐ **Yes** ☐ **No**

AUTHORIZED BY (W/C Representative): _____ **Date:** _____

Annual Confirmation of Continued W/C Coverage (if no changes)

Date/PSR: _____ **Date/PSR:** _____ **Date/PSR:** _____

Date/PSR: _____ **Date/PSR:** _____ **Date/PSR:** _____