

WORKERS COMP QUESTIONNAIRE / AUTHORIZATION SHEET

Patient Name: _____

AUTHORIZED FOR MD:

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: _____