

**PLEASE COMPLETE FORM & RETURN WITH MEDICAL
RECORDS & MANDATORY COVER LETTER**

IME – One Time Exam / CSO – Eval & Treat / Transfer of Care
(PLEASE CIRCLE ONE)

OC DR / LOC _____ TODAY'S DATE _____

OC MR# _____

Appointment date _____ Appointment time ____:____AM/P M

Patient Information

Name: _____ DOB ____/____/____

Address: _____ WC Body Part

Telephone #: () _____ SS# _____

Employer _____ DOI ____/____/____

Phone # _____

Billing Information

Report/Bill To: _____ Phone: _____

Attention: _____ Fax: _____

Billing Address: _____

Adjuster E-mail Address _____

Person Scheduling: _____ Email Address _____

Telephone #: () _____ Fax #: () _____

NCIC #: _____ Claim# _____

____ If the patient "No Shows", the appointment isn't cancelled within 24 hours of the appointment date, or the patient arrives for the appointment without all films relating to injury, you will be responsible for a \$250.00 fee. The appointment will be cancelled if the patient arrives without all films relating to the injury.

Date appointment canceled: ____/____/____ by whom: _____

Reason for cancellation: _____

Reschedule date: ____/____/____ Rep/Bill/No Show Letter Sent _____

____ Calendar _____ Confirm Letter _____ Payment Received

____ Patient Letter _____ Invoice Sent

FAX TO 704-945-7684

Revised by Sharon Blanding 4/21/2008