

(OC WC Department Only)
 Today's Date:
 Patient #:
 Date/Time of Appt:
 Location:
 Provider:

OrthoCarolina Workers' Compensation New Patient Demographic | Authorization Form

Patient Name:	Date of Birth:
Patient Mailing Address:	
Patient Email Address:	Phone #:
Social Security #:	Date of Injury/Injured Body Part:
Employer:	Contact:
Address:	Phone#:
Where has patient been treated?	Have X-Rays been done? <input type="checkbox"/> Yes <input type="checkbox"/> No
Case Manager: please circle (Telephonic/Field)	Phone #:
Email Address:	Fax #:
WC Insurance Carrier:	WC Claim #:
Billing Address:	
Bill Review Company:	Telephone/Email Address:
Adjuster Name:	Email Address:
Phone #:	Fax #:

Locations:

CHARLOTTE SPECIALTY CENTERS: <input type="checkbox"/> Foot & Ankle <input type="checkbox"/> Shoulder/Elbow <input type="checkbox"/> Hand <input type="checkbox"/> Spine <input type="checkbox"/> Hip & Knee <input type="checkbox"/> Sports <input type="checkbox"/> Pediatrics	ALL OTHER LOCATIONS: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Ashe</td> <td><input type="checkbox"/> Gastonia</td> <td><input type="checkbox"/> Laurinburg</td> <td><input type="checkbox"/> Shelby</td> </tr> <tr> <td><input type="checkbox"/> Ballantyne</td> <td><input type="checkbox"/> Hickory</td> <td><input type="checkbox"/> Matthews</td> <td><input type="checkbox"/> Taylorsville</td> </tr> <tr> <td><input type="checkbox"/> Bennettsville</td> <td><input type="checkbox"/> Hudson</td> <td><input type="checkbox"/> Monroe</td> <td><input type="checkbox"/> University</td> </tr> <tr> <td><input type="checkbox"/> Blakeney</td> <td><input type="checkbox"/> Huntersville</td> <td><input type="checkbox"/> Mooresville</td> <td><input type="checkbox"/> Wilkes</td> </tr> <tr> <td><input type="checkbox"/> Boone</td> <td><input type="checkbox"/> Kernersville</td> <td><input type="checkbox"/> Pembroke</td> <td><input type="checkbox"/> Winston Salem</td> </tr> <tr> <td><input type="checkbox"/> Clemmons</td> <td><input type="checkbox"/> King</td> <td><input type="checkbox"/> Pineville</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Concord</td> <td><input type="checkbox"/> Lincolnton</td> <td><input type="checkbox"/> Rock Hill, SC</td> <td></td> </tr> </table>	<input type="checkbox"/> Ashe	<input type="checkbox"/> Gastonia	<input type="checkbox"/> Laurinburg	<input type="checkbox"/> Shelby	<input type="checkbox"/> Ballantyne	<input type="checkbox"/> Hickory	<input type="checkbox"/> Matthews	<input type="checkbox"/> Taylorsville	<input type="checkbox"/> Bennettsville	<input type="checkbox"/> Hudson	<input type="checkbox"/> Monroe	<input type="checkbox"/> University	<input type="checkbox"/> Blakeney	<input type="checkbox"/> Huntersville	<input type="checkbox"/> Mooresville	<input type="checkbox"/> Wilkes	<input type="checkbox"/> Boone	<input type="checkbox"/> Kernersville	<input type="checkbox"/> Pembroke	<input type="checkbox"/> Winston Salem	<input type="checkbox"/> Clemmons	<input type="checkbox"/> King	<input type="checkbox"/> Pineville		<input type="checkbox"/> Concord	<input type="checkbox"/> Lincolnton	<input type="checkbox"/> Rock Hill, SC	
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Preferred Vendor Section:

Will Ancillary Services be approved through OrthoCarolina? MRI / EMG / PHYSIATRY / SYNVISIC / EUFLEX / PHYSICALTHERAPY <input type="checkbox"/> Yes <input type="checkbox"/> No (if no please indicate preferred vendor) :
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*By signing the authorization form you are giving authorization for patient to receive treatment with OrthoCarolina for the following:
 Consult, Treatment, Lab, and X-ray's.*

*Please specific in the preferred vendor section if services will be approved through OrthoCarolina or outside vendor which will have to
 be set up by the WC Carrier if ordered by the Physician.*

**Per North Carolina Industrial Commission authorization should be provided within 7 business days and notification of receipt of
 referral should be given within 2 business days.**

Adjuster Signature:	Date:
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