# SPECIAL EXAM PROTOCOL

Special Exams are $1,500.00 prepaid.

Enclosed is the OrthoCarolina Special Exam Form. Please complete, sign and send to the Special Exam Coordinator.

1) Please provide a cover letter outlining the specific concerns to be addressed during the exam.
2) Please submit Medical records in the following order:
   - Operative Notes
   - Diagnostic Test Results/Procedure Notes
   - Clinical Notes to include OrthoCarolina notes only pertaining to the specific body part to be evaluated
   - (These notes should be separated by provider and in descending order)
   - Urgent Care, Occupational Medicine and ED/ER Notes
   - FCE, Prior IME/CSO's and miscellaneous results with medical significance pertaining to the exam

**Not Required:** Attorney Correspondence, PT /OT Notes, Nursing phone call logs, HCFA Bills or work status notes. Please eliminate all duplicate copies. Flash drives and CDs are not accepted.

Medical Records exceeding 50 pages please mail to the address below. Medical records less than 50 pages, please fax to 704.945.7684 or email to kelly.winfield@orthocarolina.com or donna.adcock@orthocarolina.com.

Please note: Medical Records in excess of one inch will be invoiced at $125.00 per inch thereafter.

3) Enclosed are two forms that **may** apply to your request:
   a) Out of state authorization form for all states excluding NC or SC.
   b) The hand consent authorization form

4) A pre-pay invoice will be e-mailed to you with our mailing address and OrthoCarolina's Tax ID number. Receiving the invoice does not affirm the physician has agreed to evaluate the patient.

   If the patient is a "NO SHOW" or the appointment is not cancelled or rescheduled seven calendar days prior to the appointment date, a $250.00 fee is assessed . If the patient arrives without **ALL** films related to the injury, the appointment will be cancelled and a $250.00 fee is assessed. The appointment will not be rescheduled until the $250 fee is received.

**THE SPECIAL EXAM APPOINTMENT PROCESS MAY TAKE UP TO FOUR WEEKS.**

***Special Exam Coordinators:***

***Kelly Winfield, 704.323.2216 or Donna Adcock, 704.323.2317***

4601.Park Road. Suite 300. Charlotte. North Carolina Phone. 704.323.2667 Fax. 704.945.7684

***Workers.compensation@orthocarolina.com***

OrthoCarolina

**WORKERS' COMPENSATION SPECIAL EXAM INFORMATION FORM – FAX: 704-945-7684**

( ) IME : This is an Independent Medical Evaluation

( ) CSO: This is a Comprehensive Second Opinion

On the above, there will be no diagnostic tests performed unless the MD requires them to complete his/her evaluation.

These are one-time evaluations only.

( ) CSO WITH TRANSFER OF CARE (The requesting party authorizes total and complete transfer of care.)

All evaluations consist of review of all medical records, x-rays, and any other diagnostic studies.

***PATIENT INFORMATION:***

NAME: _____ DOB: _____ SSN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ E-MAIL: _____

***EMPLOYER INFORMATION:***

NAME: _____ PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

***BILLING INFORMATION:***

PARTY SCHEDULING: _____ PHONE: _____ FAX: _____

SCHEDULING PARTY'S E-MAIL: _____

REPORT/BILL TO: _____

ADJUSTER: _____PHONE: _____ FAX: _____ ADJUSTER'S E-MAIL: _____

CARRIER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

JURISDICTION: _____ CLAIM NO. _____ DATE OF INJRY: _____

BODY PART(S) TO BE EVALUATED: _____

ADJUSTER/ATTORNEY/NURSE CASE MANAGER/AUTHORIZED PARTY : _____

DATE: _____

**ORTHOCAROLINA USE ONLY**

TODAY'S DATE: _____OCN: _____ OC PHYSICIAN: _____

APPT. DAY: _____DATE: _____ TIME: _____ MD: _____LOCATION: _____

DATE APPT. CANCELLED: _____ REASON: _____

DATE APPT. RESCHEDULED: _____

INVOICE SENT ON: _____ PAYMENT RECEIVED ON: _____ CHECK NO.: _____

OrthoCarolina
EXCELLENCE IN ORTHOPEDICS

# Workers' Compensation
# OrthoCarolina's Hand Center
# Patient Policy

***For continuity of patient care our Hand Surgeons have requested:***

**Occupational Therapy, Physical Therapy, Custom Splints and DME be provided at an OrthoCarolina Facility.**

*** If utilizing an outside facility, please provide the Hand Therapist's name for O.C. Hand Surgeon agreement*

***Please fax completed form to 704.323.2007 or email us @ workers.compensation@orthocarolina.com***

A representative from OrthoCarolina's Workers' Compensation Department will contact you to schedule the appointment. Any Physical Therapy or Occupational Therapy required after surgery needs pre-authorization.

Thank you in advance for your referral.

**Today's Date: _____**

_____ _____
**Adjuster's Name (please print)** **Adjuster's email address**

_____
**Adjuster's Signature**

_____ _____
**Patient's Name** **Date of Birth**

_____
**Insurance Carrier**

_____
**Insurance Carrier's Address**

_____ _____
**Insurance Carrier's Telephone** **Insurance Carrier's Fax**

_____ _____
**Date of Injury** **Claim Number**

OrthoCarolina

**OUT-OF-STATE WORKERS' COMPENSATION**
**LETTER OF AGREEMENT**

**PLEASE READ CAREFULLY AND INITIAL THE APPROPRIATE SECTIONS**

**The requesting party agrees to pay North Carolina's Industrial Commission (NCIC) Fee Schedule for all billed charges net 60 days and accept the NC Industrial Commission (NCIC) Rating Guidelines.**

**PLEASE NOTE: When forwarding the medical chart, ONLY INCLUDE: Office Visit Notes, Physician Correspondence, and Diagnostic Test Results related to the exam/service.**
**DO NOT include Attorney correspondence nor the Physical Therapy Notes.**

**PATIENT INFORMATION TO BE COMPLETED BY THE REQUESTING PARTY**

**NAME:** **DOB:**

**ADDRESS:** **PHONE:**

**CITY, STATE, ZIP:** **SS#:**

**BODY PART INJURED:** **DATE OF INJURY:**

**STATE OF JURISDICTION:**

**BILLING INFORMATION TO BE COMPLETED BY THE REQUESTING PARTY**

**REPORT/BILL TO:** **PHONE:**

**ATTENTION:** **FAX:**

**CLAIMS ADDRESS:**

**ADJUSTER'S EMAIL ADDRESS:** **CLAIM #:**

**SCHEDULER:** **FAX:**

**PHONE:** **EMAIL:**

**INITIAL _____ The INSURANCE COMPANY/ADJUSTER North Carolina's Industrial Commission (NCIC) Fee Schedule for all billed charges net 60 days and follow the NCIC rating guidelines.**

**EMPLOYER INFORMATION**

**EMPLOYER NAME:**

**MAILING ADDRESS:**

**CITY:** **STATE:** **ZIP:**

**PHONE:** **FAX:**

**FAX TO: 704-323-2007**