

Workers' Compensation New Patient | Authorization Form

Medicals are required prior to scheduling

Email: workers.compensation@orthocarolina.com

Patient Name:	Date of Birth:
Preferred Language:	Male or Female:
Patient Mailing Address: Street #, City, State	
Patient Email Address:	Phone #:
Social Security #:	Date of Injury:
Employer:	Injured Body Part:
Address:	Phone#:
Has this patient received treatment? <i>If yes, indicate where, records must be provided</i>	Has surgery occurred for this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please check all that apply- Please advise if patient has had any of the following: <i>If yes, reports are required prior to scheduling.</i> <input type="checkbox"/> X-rays <input type="checkbox"/> CT <input type="checkbox"/> MRI	
Case Manager Name: please circle (Telephonic/Field)	Phone #:
Email Address:	Fax #:
WC Insurance Carrier:	WC Claim #:
Billing Address:	Jurisdiction:
Bill Review Company:	Telephone/Email Address:
Adjuster Name:	Email Address:
Phone #:	Fax #:
Specify Provider and / or Location:	

By signing the New Patient/Authorization Form below, you are providing approval for OrthoCarolina to conduct the following services:


Consultation Treatment Labs X-ray EMG/NCS (location exceptions Hickory, Winston, Laurinburg) CT Scans- (Hand Center / Foot and Ankle Center) SAME DAY CT SCANS Post-Surgical Custom Splints	<p align="center"><u>Hand Surgeon Request:</u></p> <p>Occupational Therapy, Physical Therapy, and DME provided at OrthoCarolina. ** If utilizing an outside facility, please provide the Hand Therapist's name for O.C. Hand Surgeon agreement</p>
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Preferred Vendor Section:

Will Ancillary Services be approved through OrthoCarolina? MRI / PHYSICAL THERAPY/ POST SURGICAL DME

Yes No (if no please indicate preferred vendor) :

Adjuster and/or Employer Signature:

	Date:
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OrthoCarolina - Workers' Compensation Department - 4601 Park Road - Suite 300 - Charlotte - NC - 28209

WC Call Center: (P) 704.323.2667 (F) 704.323.2007

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