OrthoCarolina

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?	**Has surgery occurred for this injury?** ☐ Yes ☐ No
Has the patient received X-Rays, CT, and/or MRI? ☐ Yes ☐ No	
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**	***Hand Surgeon Request:*** 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*

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:

SIGN HERE	**Date:**

OrthoCarolina - Workers' Compensation Department - 4601 Park Road - Suite 300 - Charlotte - NC - 28209
WC Call Center: (P) 704.323.2667 (F) 704.323.2007
Email: workers.compensation@orthocarolina.com