[](http://www.orthocarolina.com/)

**Workers’ Compensation**

**New Patient | Authorization Form**

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| **Patient Name:** | **Date of Birth:** |
| **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, MRI etc?**  Yes  No | | |
| **Case Manager Name: please circle (Telephonic/Field)** | **Phone #:** |
| **Email Address:** | **Fax #:** |
| **WC Insurance Carrier:** | **WC Claim #/ Jurisdiction:** |
| **Billing Address:** | | |
| **Bill Review Company:** | **Telephone/Email Address:** |
| **Adjuster Name:** | **Email Address:** |
| **Phone #:** | **Fax #:** |

**Locations:**

|  |  |
| --- | --- |
| **CHARLOTTE SPECIALTY CENTERS:**  Foot & Ankle Shoulder/Elbow  Hand  Spine  Hip & Knee  Sports  Pediatrics | **ALL OTHER LOCATIONS:**  Ballantyne  Hickory  Matthews  Taylorsville  Bennettsville  Hudson  Monroe  University  Blakeney  Huntersville  Mooresville  Winston-Salem  Boone  Kernersville  Pembroke  Clemmons  King  Pineville  Concord  Lincolnton  Rock Hill, SC  Gastonia  Laurinburg  Shelby |

**Preferred Vendor Section:**

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| --- |
| **Will Ancillary Services be approved through OrthoCarolina?** MRI / PHYSICAL THERAPY/ POST SURGICAL DME  Yes  No (if no please indicate preferred vendor) : |

***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, EMG, NCS***

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| --- | --- |
| Image result for sign here**Adjuster Signature:** | **Date:** |