

**Workers’ Compensation**

**New Patient | Authorization Form**

|  |  |
| --- | --- |
| **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:**

|  |
| --- |
| **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***

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