SPECIAL EXAM PROTOCOL

Special Exams are $2,500 prepaid.

- *Medical Records in excess of one inch will be invoiced at $125.00 per inch thereafter.*
- *No Show / Late Cancellation Fee- $250.00*

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

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, Email: special.exams@orthocarolina.com

Procedure:

- The Special Exam request will be sent to Physician for review/consideration and at the same time an invoice will be submitted to requesting party for payment.
- After receipt of the Physician's consideration and after receipt of the pre-payment an appointment will be scheduled accordingly.
- The Special Exam process could take up to four weeks from the date of receipt.

Special Exam Coordinators:

Kelly Winfield, 704.323.2216 or Donna Adcock, 704.323.2317
Email Address: special.exams@orthocarolina.com

4601. Park Road. Suite 300. Charlotte. North Carolina

Revised 05/2019

OrthoCarolina

WORKERS' COMPENSATION SPECIAL EXAM INFORMATION FORM

☐ 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:_____

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: _____

DATE: _____ SPECIFY REQUESTED PROVIDER: _____

By signing this Form below, you are providing approval for OrthoCarolina to conduct the following services: *(EXCEPTION: IME / CSO)*

Consultation **Treatment** **Labs** **X-ray** **CT Scans-** *(Hand Center / Foot and Ankle Center) SAME DAY CT SCANS*	***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*

 **Authorizing Party:**	**Date:**

ORTHOCAROLINA USE ONLY

DATE RECEIVED: _____MRN: _____ PHYSICIAN REQUESTED: _____

APPT DATE/LOCATION: _____

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OUT-OF-STATE WORKERS' COMPENSATION LETTER OF AGREEMENT

PLEASE READ CAREFULLY AND SIGN 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.

Patient Name:	**Date of Birth:**
Injured Body Part:	**Date of Injury:**
WC Claim #:	**Jurisdiction:**
Employer:	**Employer Phone #:**
Address:	
Case Manager Name: please circle (Telephonic/Field)	**Phone#:**
Email Address:	**Fax #:**
WC Insurance Carrier:	**Phone#:**
Adjuster Name:	**Fax #:**
Email Address:	

By signing: The Insurance Carrier/ Adjuster are in agreement to the North Carolina's Industrial Commission (NCIC) Fee Schedule for all billed charges net 60 days / NCIC rating guidelines.

Carriers Signature:

	**Date:**

OrthoCarolina - Workers' Compensation Department – 4601 Park Road - Suite 300 - Charlotte - NC – 28209
Email: special.exams@orthocarolina.com

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