Workers' Compensation Initial Authorization Form

Today's Date:

Appt Date/Time:

Treating Physician:

Clinic Contact: Worker's Compensation Specialist

Contact Phone: 662-370-1986/ 662-328-1012

Clinic Fax: 662-328-9918

Contact Email:

From: **COLUMBUS ORTHOPAEDIC**
670 Leigh Dr
Columbus, MS 39705

PATIENT INFORMATION

Name:

Address:

City, State, Zip:

Phone:

Date Of Birth: **Sex:** **M** **F**

Social Security #

Date Of Injury:

Type of Injury:

How did injury occur?

Previous Treatment/Films:

EMPLOYER INFORMATION

Employer:

Address:

City, State, Zip:

Phone:

Employer Contact:

Treatment Already Authorized? **Yes / No**

If yes, by whom?

NCM:

Email/Phone:

NCM Fax:

Adjuster:

Email/Phone:

W/C Carrier:

Address:

WC Claim #

Special Instructions and/or Other Comments:

Fax(emp):

Fax(adj):