COLUMBUS ORTHOPAEDICS
TEAM PHYSICIANS

NEEDED WORKER'S COMPENSATION INFORMATION

Once you obtain the information needed you or your adjuster may email a copy of this form to workcomp@columbusortho.com.

A written authorization will need to be obtained via (email listed above) or via fax 662-328- 9918.

Once the authorization is received you will be contacted for an appointment.

If you have received any imaging for this injury you will need to bring the disc with the imaging on it to your appointment.

Information needed for scheduling

LEGAL first and last name PRINTED: _____

Your Billing Address: _____

Date of Birth: _____

Social Security Number: _____

Primary Phone Number: _____

Email address: _____

YOU are responsible for providing **ALL** of the information needed.

Worker's Compensation Coordinator

662-362-8916

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NEEDED WORKER'S COMPENSATION INFORMATION

Adjuster's Information:
Name , phone number, and email address - **MUST HAVE ALL 3**

Claim Number:

Place of Employment:
Business name and phone number - **PROVIDE MANAGER'S NAME AND NUMBER**

Injured Body Part(s):
List all that apply (the body part(s) that you re ported) - **SPECIFY LEFT OR RIGHT**

Date you were Injured: (Month/Day/Year)

Work Comp Ins. Company Name and Claims Billing address: