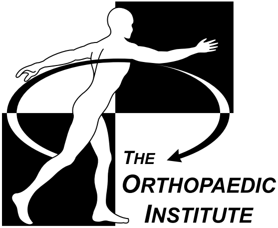

WORK COMP INITIAL VISIT AUTHORIZATION FORM

Date ________________ DOB ________________ Patient Account # ________________

Patient Name ____ SSN ________________

Claim # ________________________________ Date of Injury _______________________

Contracted Network ____

Employer____

Phone # __________________Fax # __________________Email____________________

Insurance Company Information:

Name____

Address ____

Phone # __________________Fax # _________________Email____________________

Description of Ailment ____

	☐ Initial Visit Eval and Treat	☐ IME	☐ Second Opinion	☐ Record Review
FEES:	☐ ____________	☐ ____________	☐ $400.00	☐ $125.00
CODES:	☐ ____________	☐ ____________	☐ 99205, WC	☐ 99080

Date of Appointment ____________________ Physician __________________________

DME Authorization ____

Adjuster Name____

Phone # __________________Fax # _________________Email____________________

Nurse Case Manager Name____

Phone # __________________Fax # _________________Email____________________

Special Instructions ____

Name of Authorized Agent (Print) ____

Signature of Authorized Agent __________________________________ Date __________

Work Comp Department
Phone (386) 518-6870
Fax (352) 336-6046