NEW Patient Contact Information
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WORKER'S COMP - NEW PATIENT REFERRAL FORM

DATE: _____

REFERRING DOCTOR: _____NPI:_____

PHONE: (_____)_____ FAX: (_____)_____

PATIENT INFORMATION

NAME: _____

DOB: _____ SSN: _____ GENDER ❑ M ❑ F

PHONE: (_____) _____ ALT PHONE: (_____) _____

ADDRESS: _____

DIAGNOSIS CODE and DESCRIPTION: _____

_____

CLAIM INFORMATION

DOI/DOA: _____ W/C INSURANCE CARRIER: _____

CLAIM NUMBER: _____ CLAIM ADDRESS: _____

_____

CASE MANAGER NAME: _____ PHONE: (_____) _____

EMAIL: _____ FAX: _____

EMPLOYER INFORMATION

EMPLOYER NAME: _____ PHONE: _____

ADDRESS: _____

APPROVED SERVICES: TO BE COMPLETED BY CASE MANAGER

AUTHORIZATION NEEDED FOR OFFICE VISITS? __ YES __ NO

AUTHORIZATION NEEDED FOR PROCEDURES? __ YES __ NO

AUTHORIZATION NEEDED FOR DME? __ YES __ NO

PATIENT CAN BE TREATED BY ANY PROVIDER AT OUR PRACTICE? __ YES __ NO

IF NOT, WHICH PROVIDERS CAN TREAT PATIENT?:_____

DWC-25 REQUIRED AT EVERY OFFICE VISIT? __ YES __ NO

DWC-25 REQUIRED AT PROCEDURES? __ YES __ NO

W-9 FORM REQUIRED? __ YES __ NO