WORKERS' COMPENSATION SCHEDULING SHEET

Appt info: Dr: _____ Date: _____ Time:_____ NCM to attend: Yes No

MRN# _____ DOB: _____ SSN: _____

Patient's Name _____ Male/Female

Address: _____ Zip: _____ Phone: _____

Pt's Email: _____ Nextgen # _____ (if applicable)

Referring MD _____ MD. Phone No._____ MD.Fax _____

DOI: _____ Injury Site(s) _____ [ ] Right [ ] Left

TREATMENT INFORMATION

Claim No._____ **State in which injury occurred:** _____ [See highlighted area below]

Eval and treat _____ Eval only_____ 2nd op _____ Emp Self pay _____ Prior approval required per visit: _____

Authorized by _____ Title _____ Date _____

Phone _____ Ext _____ Fax _____

Email: _____

EMPLOYER INFORMATION

Employer _____ Contact Person _____

Phone _____ Ext _____ Fax _____ **Email** _____

Is this employer affiliated with the Federal\Government or Dept of Labor? [ ] yes [ ] No
The carrier/employer agrees that this treatment will be reimbursed at the SCWC fee schedule & coding guidelines [ ] Yes [ ] No

CARRIER INFORMATION

Name _____ **Email**: _____ Phone: _____

Address _____ Website: _____ Fax: _____

City _____ State _____ Zip _____

Adjuster _____ Phone _____ Ext _____

Email: _____ Fax _____

Nurse Case Mgr _____ Phone _____ Ext _____

Email: _____ Fax _____

Notes:

_____

_____

Patient to bring [ ] X-rays [ ] MRI [ ] other _____ Medical Records Requested [ ] Yes [ ] No Revised 6/24/15