Written Auth. for Workers' Comp Appt.

Please note that a delay in your response may lead to a delay in the injured worker's return to duty status .

Appointment for _____

Date: _____ **Appointment date** _____

ATTENTION: _____

Highland Health
2930 Village Drive
Fayetteville, NC 28304
Telephone # : (910) 323-9010, Ext. 330
Fax# : (910) 829-9530

FROM: Insurance Authorizations

RE: _____
Patient's Name

Insurance Co. Billing Address :

_____
SSN

_____
Company Name

_____
Date of Injury

_____
PO Box or Street Address

_____
W/C Claim / File #

_____
City, State, Zip

Requesting authorization for one of the following services:

(*To be determined after records are received*)

IME (Independent Medical Evaluation) $350.400.00 to $750.00
No Show fee = $125.00

If authorization and medical notes are not received by the day before this appointment, this appointment will have to be rescheduled for another time, after receipt of these items.

_____ _____ _____
Adjuster's Name Phone# Fax#

_____ _____ _____
Case Manager's Name Phone# Fax#

***** PLEASE SIGN AND FAX BACK TO THE NUMBER LISTED ABOVE ASAP*****
*****APPOINTMENT PENDING RECEIPT*****

This form confirms that authorization has been given for the appointment referenced above.

_____
Signature of representative referring patient for appointment

_____
Title

_____ _____
Telephone # Fax #