Written Auth. for Workers' Comp Appt.

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

Email:
insuranceauthorization@physicianstotalrehab.com

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

Request authorization for one of the following services:

(*To be determined after records are received*)

CPT 99245 NP CONSULT, IME02 = $250.00, OR IME03 = $ 400.00

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.

Form must be signed by the adjuster for first appointment.

Do you (the adjuster) give permission for us to accept authorization for further treatment from the case mar patient? **Please circle one** **Yes No**

******

_____ _____
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 appt Title

_____
Telephone # Fax #

_____
Patient's Address

_____ _____
Patient Telephone # Patient DOB