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.

Date: _____

ATTENTION: _____

Physicians' Total Rehab
2930 Village Drive
Fayetteville, NC 28304
Telephone # : (910) 323-9010, Ext. 330
Fax# : (910) 829-9530

Appointment date: _____

FROM: **Insurance Authorizations**

EMAIL ADDRESS:
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

Requesting authorization for Initial Evaluation & treatment
PLEASE SPECIFY THE FREQUENCY AND DURATION AT THIS POINT
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*****

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 manager for this patient?
PLEASE CIRCLE ONE YES NO

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

_____ _____
Signature of representative referring patient for appt. Title

_____
Telephone # Fax #

_____
Patients Address

_____ _____
Patient Telephone # Patient DOB