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
Phone # (910) 323-9010 ext. 330
Fax # (910) 829-9530

APPOINTMENT: _____

FROM: Insurance Authorizations

Email Address:
insuranceauthorization@physicianstotalrehab.com

RE: _____
Patient's Name

INSURANCE COMPANY BILLING ADDRESS:

_____
SSN

_____
Company Name

_____
Date of Injury

_____
PO Box or Street Address

_____
W/C Claim / File #

_____
City, State, Zip

Requesting Authorization for a Functional Capacity Evaluation (FCE)

*** * * PRE-PAYMENT IS REQUIRED * * ***

CPT EV100 contracted @$585.00 per session. NO-SHOW FEE contracted @$225.00.

A MINIMUM 48-HOUR NOTICE IS REQUIRED TO PREVENT THE $225.00 NO-SHOW FEE.

If authorization and medical notes are not received 2 business days before the appointment date, the appointment will have to be rescheduled 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 AS SOON AS POSSIBLE ****

**** APPOINTMENT PENDING RECEIPT ****

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

Signature of representative referring patient for appointment

Title

Phone #	Fax #