Attn: _____ FAX: _____

ORTHOWEST

TOTAL ORTHOPEDIC SOLUTIONS

ORTHOWEST
Clinic 150 Clinic Avenue, Suite 101 Carrollton, GA 30117 Phone: 770-834-0873
Fax: 770-834-6118

WORKERS COMPENSATION AUTHORIZATION FORM

We are requesting an appointment with one of the physician at the Orthowest for one of our Employees. We understand that we and/or our insurance carrier are responsible for payment of services rendered.

WC Law requires payment within 30 days of receipt of charges.

**** ALL INFORMATION REQUIRED ****

Employee's Name:	Insurance Carrier:
Date of Birth:	Phone:
SS #:	FAX:
Claim number:	Adjuster:
Employer Name:	E-mail address:
Address:	Claims Billing Address:
Phone:	**Do you want us to:**
FAX:	○ Send bills directly to you (the Employer)
Contact Person:	
Body Part(s) Authorized:	○ Send bills directly to the Insurance Carrier
Date of Injury:	

***** PLEASE PROVIDE A WRITTEN JOB DESCRIPTION FOR INJURED WORKER *****

* Are there Light Duty jobs available, if necessary? Yes _____ No _____

If Yes, please provide a written job description detailing the light duty work that is available.

_____
_____
_____

Authorized Signature: _____ Date: _____

Please make sure that you file a claim with your work comp insurance carrier and fax this paperwork to the fax number above ***BEFORE*** *making the claimant's appointment.* ***WE ONLY ACCEPT GEORGIA WORKERS COMP.***

Note: Carrollton Orthopaedic Clinic DOES NOT participate with any PPO Plans including Aetna and Integrated for the processing of Workers Compensation Claims. ALL WC claims should be reimbursed at 100 % of the Georgia Workers Compensation Fee Schedule.