

# WORKER'S COMPENSATION VERIFICATION

TENNESSEE SPINE & JOINT CENTER, P.C.

**DATE OF APPOINTMENT:** \_\_\_\_\_

**PATIENT INFORMATION:**

Patient Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ DOB: \_\_\_\_\_

SSN: \_\_\_\_\_

**EMPLOYMENT INFORMATION:**

Date of Injury: \_\_\_\_\_ Type of Injury: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Attention: \_\_\_\_\_ Phone#: \_\_\_\_\_

**WORKER'S COMPENSATION CARRIER**

Carrier's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**Adjuster:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

**Nurse Case Manager:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

**Claim#:** \_\_\_\_\_

**Send Bill To:**            **Employer**            **W/C Carrier**

**Referred BY:** \_\_\_\_\_

**Verified By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Type of Visit:** 2<sup>nd</sup> Opinion    Evaluate&Treat    Evaluation Only    **IME**

**Notes Faxed To:** \_\_\_\_\_

**Who can approve further treatment?** \_\_\_\_\_