AZALEA ORTHOPEDICS

WORKERS' COMP CONFIRMATION

Patient Name: _____ SS#: _____ Date of Birth: _____

Address: _____ City / State / Zip: _____

Home Phone: _____ Cell Phone: _____ Referred by: _____

Insurance Company: _____ Claim #: _____

Address: _____ City / State / Zip: _____

Phone: _____ Fax: _____

Pre-Authorization Phone: _____ Pre-Authorization Fax: _____

Adjuster: _____ Phone: _____ Fax: _____

Case Manager: _____ Phone: _____ Fax: _____

Are there any disputes pending on this claim? YES ☐ NO ☐
If yes, explain: _____

Is the Insurance Company a Subscriber to DWC? YES ☐ NO ☐
If no, is the Insurance Company – ☐ Self-Insured ☐ Occupational

Does this claim go through a network? YES ☐ NO ☐
If yes, name of network: _____

Ailment or Injury: _____ Date of Injury: _____

Employer: _____ Contact person: _____

Address: _____ City / State / Zip: _____

Phone: _____ Fax: _____

Treating Doctor: _____

Address: _____ City / State / Zip: _____

TDR Phone: _____ TDR Fax: _____

Appointment info obtained from: _____ Date: _____ By: _____

W/C claim approval obtained from: _____ Date: _____ By: _____

Appointment Date / Time: _____ Doctor: _____