



# WORK COMP EMPLOYER AUTHORIZED INITIAL VISIT FORM

Date \_\_\_\_\_ Patient Account # \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Employer Name \_\_\_\_\_ Date of Injury \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

Authorization for:       Evaluation Only                       Evaluation and Treatment  
                                  Medication Dispensing                       Durable Medical Equipment Dispensing

Nature of Injury \_\_\_\_\_

Date of Appointment \_\_\_\_\_ Physician \_\_\_\_\_

Name of Authorized Agent (Print) \_\_\_\_\_

Signature of Authorized Agent \_\_\_\_\_ Date \_\_\_\_\_