WORK COMP INITIAL VISIT AUTHORIZATION FORM

Date _____ DOB _____ Patient Account # _____

Patient Name _____ SSN _____

Claim # _____ Date of Injury _____

Contracted Network _____

Employer_____

Insurance Company Information:

Name_____

Address _____

Phone # _____Fax # _____Email_____

Description of Ailment _____

_____

	☐Initial Visit Eval and Treat	☐IME	☐Second Opinion	☐Record Review
FEES:	☐_____	☐_____	☐$400.00	☐$125.00
CODES:	☐_____	☐_____	☐99205, WC	☐99080

Date of Appointment _____ Physician _____

DME Authorization _____

Adjuster Name_____

Phone # _____Fax # _____Email_____

Nurse Case Manager Name_____

Phone # _____Fax # _____Email_____

Special Instructions _____

Name of Authorized Agent (Print) _____

Signature of Authorized Agent _____ Date _____

Work Comp Department
Phone (352) 336-6004
Fax (352) 336-6046