GEORGIA SPINE
& Orthopedics

**WORKERS COMPENSATION INSURANCE VERIFICATION**

Approved DOCTOR _____LOCATION _____

APPOINTMENT DATE/TIME: _____

Patient Name _____ DOB _____

Address _____

Phone _____ Work _____ SS# _____

Area of Body/Complaint _____

Has patient had treatment prior ____Y ____ N If yes, where _____

Is this a GA Work Comp Claim ___ Y ___ N Medical Record Review Approved ____ Y _____N

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Employer (at time of injury) _____

Contact _____ Address _____

Employer Phone _____ Fax _____

Insurance Carrier _____Adjuster _____

Adjuster Phone _____ Adjuster Fax _____

Claim Number _____

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Case Manger _____

Authorized by _____Employer _____ Case Manager _____ Insurance Adjuster

Type of Visit _____Eval/Treat _____Eval Only _____2nd Op _____2nd Op w/tx _____ IME

Patient to bring _____ MRI _____ CT _____ Records _____ Other