SPECIALTY CLINICS OF GA-ORTHOPAEDICS, PC

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AUTHORIZATION FOR WORK COMP TREATMENT

Patient Name:
SS#:
Date of Birth:
Requested Appointment date & time:
Physician to see:
Employer:
Employer Phone#:
Employer Fax#:
Contact person:
Insurance company:
Insurance company billing address:
Claim#:
Insurance Fax:
Adjuster Name:
Adjuster Email Address:
Adjuster Phone w/ Ext:

Services Requested:

EVAL ONLY_____ EVAL & TREAT _____ 2nd OPINION _____ IME _____

Date of injury:____

Type of injury/area to be treated: ____

Name of ATP: ____

Is Limited Duty available for patient? ___ Yes ___No

Is the patient currently working? ___Yes ___No

Has there been prior treatment for this injury? ___Yes ___No

If yes, what is the name & phone number of the physician:

____

Please send the bill to:____________ Employer: ____________ Insurance company

I authorize Specialty Clinics of Georgia-Orthopaedics, P.C. to treat the above named employee for his/her injuries listed above. I authorize payment based on the current Georgia Workers Comp fee schedule.

Signed ______________________________ ______________________________

Signature of person giving authorization Print name of person giving authorization

Please complete and sign this form, then fax to (678)707-7156 or email to workcomp@scgsecure.com along with the first report of injury prior to the patients appointment. If signed authorization is not received 24 hours in advance, the patient's appointment will be cancelled.

Thank you.