TOA
TENNESSEE ORTHOPAEDIC ALLIANCE

**WORKERS' COMPENSATION INSURANCE VERIFICATION**

Doctor_____ Account Number_____

Location_____ Appointment Date/Time_____

Referring Physician_____Phone_____

Referring Physician Address_____

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Patient Name_____DOB_____

Address_____

Phone#_____Work#_____SS#_____

Area of Body/Complaint_____

Has patient had treatment prior____yes___no. If yes, where_____

Is this a TN Work Comp Claim ___yes ___no. If no, please complete TN out of State agreement

Medical record review approved___yes___no. Interpretation needed _____yes_____no

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Employer (at time of injury)_____

Contact_____Address_____

Employer phone_____Fax_____

Insurance Carrier_____

Address_____Adjuster_____

Adjuster phone_____Ext_____Fax_____

Claim number_____

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Case Manager_____Field_____Telephonic_____

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_____

Appointment Scheduled by_____