TOA
TENNESSEE ORTHOPAEDIC ALLIANCE

WORKERS' COMPENSATION INSURANCE VERIFICATION

Doctor _____ Account # _____

Location _____ Appointment Date/Time _____

Referring Physician _____ Phone # _____

Referring Physician Address _____

Patient Name _____ DOB _____
(Last) (First) (Middle)

Address _____

Phone# _____ Work # _____ SS # _____

Area of Body/Complaint _____ DOI _____

Has patient had treatment for this injury? ☐ no ☐ yes. If yes, where? _____

TN Work Comp Claim? ☐ no ☐ yes. If no, State is _____. Need signed Out-of-State agreement

Medical record review approved? ☐ no ☐ yes. Language interpreter needed? ☐ no ☐ yes

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Employer (at time of injury) _____

Address _____

Employer Phone # _____ Fax # _____

Contact Person _____

Insurance Carrier _____

Address _____

Adjuster _____

Phone # _____ Ext # _____ Fax # _____

Claim # _____

Case Manager _____ ☐ Field ☐ Telephonic

Phone # _____ Ext # _____ Fax # _____

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 _____ Date: _____