WEST TENNESSEE BONE & JOINT
Sports Medicine • Orthopedic Excellence

Workers' Compensation Initial Authorization Form

Today's Date: _____ **From:** WTBJC

Appt Date/Time: _____ 24 Physicians Drive

Treating Physician: _____ Jackson, TN 38305

Clinic Contact: Worker's Compensation Specialist

Contact Phone: 731-410-2322/731-410-2321

Clinic Fax: 731-410-2376

Contact Email:

PATIENT INFORMATION

Name: _____ **Date Of Injury:** _____

Address: _____ **Type of Injury:** _____

City, State, Zip: _____ **How did injury occur?** _____

Phone: _____ **Previous Treatment/Films:** _____

Date Of Birth: _____ **Sex: M F**

Social Security # _____

EMPLOYER INFORMATION

Employer: _____ **NCM:** _____

Address: _____ **Email/Phone:** _____

City, State, Zip: _____ **NCM Fax:** _____

Adjuster: _____

Phone: _____ **Email/Phone:** _____

Employer Contact: _____ **W/C Carrier:** _____

Treatment Already Authorized? Yes / No **Address:** _____

If yes, by whom? _____ **WC Claim #** _____

Special Instructions and/or Other Comments: _____

Fax(emp): **Fax(adj):**