Workers' Compensation Initial Authorization Form

Today's Date: ______________________ From: WTBJC

Appt Date/Time: ______________________ 24 Physicians Drive

Treating Physician: ______________________ Jackson, TN 38305

Clinic Contact: LaCinda Boggs; Dena Simko

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

Clinic Fax: 731-410-2376

Contact Email: lmboggs@wtbjc.com / dsimko@wtbjc.com

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):