John Doe Chiropractic and Wellness Center

Worker's Compensation Verification Form

Patient Account #: _____

Section 1 - Patient Data

Injured Worker's Name: _____

Date of Birth: _____ Date of Injury: _____

SS#/ID#: _____ Date of 1st. visit: _____

Section 2A - Employer Information

Employer: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

EMPLOYER Self-Insured? ◯Yes ◯No Federal? ◯Yes ◯No

Filed First Report of Injury? ◯Yes ◯No

Contact: _____

Assigned Claim #: _____

Authorization Status: ◯Pending ◯Denied Authorized Date: _____

Section 2B - Referral

Is referral required from other physician? ◯Yes ◯No

Has referral been received? ◯Yes ◯No Date of referral: _____

Physician Name: _____ Phone Number: _____

Office Name: _____ Fax Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Notes Requested? ◯Yes ◯No Notes Received? ◯Yes ◯No

Section 2C - Authorization Notes

Section 3 - Worker's Compensation Carrier

Carrier/MCO: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Website URL: _____

Case Manager: _____

Case Manager Email: _____

Claim #: _____ Other ID #: _____

Claim Denied: ◯Yes ◯No Date: _____ Denial Reason: _____

Authorized by: _____ Date: _____

Approval Details (Allowed Conditions, DX, Injury, Visit#): _____

_____

Proof of Auth. Rcvd.: ◯Yes ◯No If yes, ◯Fax ◯Email Other: _____

MCO/WC Billing Information: _____

Address: _____

City: _____ State: _____ Zip: _____

Notes sent with claim: ◯Yes ◯No Notes sent by Fax: ◯Yes ◯No Fax#: _____

Other Billing Requirements:

Process for Submitting Treatment Request:

Misc. Notes:

Section 4- Verification Box

Spoke to: _____

Date: _____

Reference #: _____

CA Initials: _____

Contact #: _____