Attn: _____ FAX: _____

Carrollton Orthopaedic Clinic
150 Clinic Avenue, Suite 101
Carrollton, GA 30117
Phone: 770-834-0873
Fax: 770-834-6118

WORKERS COMPENSATION AUTHORIZATION FORM

We are requesting an appointment with one of the physician at the Carrollton Orthopaedic Clinic, P.C. for one of our Employees. We understand that we and/or our insurance carrier are responsible for payment of services rendered.

WC Law requires payment within 30 days of receipt of charges.

**** ALL INFORMATION REQUIRED ****

Employee's Name:	Insurance Carrier:
Date of Birth:	Phone:
SS #:	FAX:
Claim number:	Adjuster:
Employer Name:	E-mail address:
Address:	Claims Billing Address:
Phone:	**Do you want us to:**
FAX:	○ Send bills directly to you (the Employer)
Contact Person:	
Body Part(s) Authorized:	○ Send bills directly to the Insurance Carrier
Date of Injury:	

***** PLEASE PROVIDE A WRITTEN JOB DESCRIPTION FOR INJURED WORKER *****

* Are there Light Duty jobs available, if necessary? Yes _____ No _____

If Yes, please provide a written job description detailing the light duty work that is available.

_____
_____
_____

Authorized Signature: _____ Date: _____

Please make sure that you file a claim with your work comp insurance carrier and fax this paperwork to the fax number above ***BEFORE*** *making the claimant's appointment.* ***WE ONLY ACCEPT GEORGIA WORKERS COMP.***

Note: Carrollton Orthopaedic Clinic DOES NOT participate with any PPO Plans including Aetna and Integrated for the processing of Workers Compensation Claims. ALL WC claims should be reimbursed at 100 % of the Georgia Workers Compensation Fee Schedule.