Worker's Compensation / Auto Accident/ Liability
Pre-Authorization & Approval Form

Patient Name: ________________________ Date of Injury: ________________________

Name of Employer/Company: ________________ Phone # of Employer: ______________

Place of Accident _____________________ Town ________________ State __________

Name of Case Adjustor / Case Manager:_______________________________________

Phone # of Case Adjustor/ Case Manager:_____________________________________

Case/Claim Number: ____

Was Employer/Company Notified of Injury: Yes ___ No ___
Have you seen a doctor: Yes ___ No ___
Has a report been filed with your employer/company: Yes ___ No ___

Specific details of injury (body part injured): _____________________________________
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To my knowledge, my employer/company and I are in agreement that my injury is being covered by Worker's Compensation/Liability. The above statements are complete to the best of my knowledge. I understand that although the insurance claims for this injury will be submitted, TEAM Physical Therapy, P.C. cannot guarantee payment, and if Workers' Compensation/Liability Insurance denies this claim, I agree to pay for all charges. My signature also gives permission for claims to be sent to the Employer/Company listed above.

The undersigned has read and completed all the above information accurately.

Signature _____________________________________ Date ___________________

Office Use Only

Referring Doctor: ____

Referral Frequency and Duration: ____

ICD10 Code(s): ____

Treating Physical Therapist: ____