ADVANCED physical medicine & therapy, ltd.

Worker's Compensation Verification Form

Section 1 - Patient Data	
Injured Worker's Name:	
Date of Birth:	Date of Injury:
SS#/ID#:	
Have you seen another physician for this injury? ◯Yes ◯ No	

Section 2 - Employer Information		
Employer:		
Address:		
City:	State:	Zip:
Did you report the injury to your employer?	Yes ◯ No ◯	
Contact:		
Assigned Claim #		

Section 3 Worker's Compensation Carrier – *please complete as much as possible contact information is required.*		
Carrier:	Phone:	
Address:		
City:	State:	Zip:
Website URL:		
Case Manager:		
Case Manager Email:		
Claim #:	Other ID	
Signature	Date:	

Office Use

Date:	Spoke With:
Reference #	
_____Approved _____ Denied	Approval Details/Limitations: (Allowed Conditions, DX, Injury, Visit#):

Billing Information

Contact Name:	Number:
Carrier Name:	
Address:	
City:	State: Zip:
	Notes sent by fax:_____ Yes_____ No Fax Number_____
Other Notes:	
Staff Member:	