CONSULTATION REQUEST

TO: Krista Duke, Workers Compensation Coordinator Fax: 850-398-6855

Date:________________________________

Which Panhandle Orthopaedics clinic would you like to schedule with?

Please click a check box below.

☐ Crestview ☐ Panama City ☐ Pensacola

Please fill out the attached form completely and fax or email to:

Krista Duke, Workers Compensation Coordinator
Mercedes Pastran, Workers Compensation Representative

Fax: 850-398-6855
Email: kduke@panhandleortho.com
mpastran@panhandleortho.com

Documentation required for review prior to scheduling an appointment:

-Fully completed authorization form
-ALL medical records pertaining to this injury
-Any detailed Job description available

IMPORTANT- Must Have All Previous Diagnostic Films & Reports

Upon receipt of the required documentation, Krista will contact you with an appointment date and time.

Questions, Comments, or Concerns:

Please contact Krista Duke or Mercedes Pastran at **850-398-8480 ext 227**

Thank you for the referral!

Panama City
200 Doctors Drive
Panama City, FL 32405
Ph: (850) 784-7724

Crestview
710 Hospital Drive
Crestview, FL 32539
Ph: (850) 398-8480

Pensacola
4724 North Davis Hwy.
Pensacola, FL 32503
Ph: (850) 398-8480

WORKER'S COMPENSATION AUTHORIZATION SHEET

Date: ______________________________
Name of Injured Worker: ______________________________ DOB: ____________
Social Security#: ____________________ Phone Number: ____________________
Address: ____________________ City ____________ State ___ Zip Code ________

NETWORK: ____________________ Employer: ____________________
Address: ____________________ City ____________ State ___ Zip Code ________
Human Resource Contact: ______________________________ Phone: ____________

Date of injury ____________________ Auth/Claim Number: ____________________
Employee job description *(Attach or give a brief description)*: ____________________
Mechanism of Injury *(Attach the 1st report of injury, or give a brief description)*: ____________________
Body part to be treated *(Please be specific)*: ____________________
Any Pre-existing conditions? ______________________________

Service you are authorizing *(Please click a check box below)*:

☐ Evaluation Only - *$500 fee for consult*

☐ Evaluation and Treatment*
*Treatment includes the following: X-Rays, Strapping, Casting to include *$100 fee* for supplies (*Q-codes*), Splinting (as needed)

If this is a request for one of the following, there is a *$500 fee* for the consultation *(Please click a check box below)*.

☐ One Time Change ☐ Transfer of Care ☐ 2nd Opinion

☐ MMI/Permanent Impairment Rating Only - *$350 fee for visit*

All other services (DME, surgical procedures, advanced imaging, etc. will be requested as needed).

Adjuster: ____________________ NCM: ____________________
Phone: __________ xt: ______ Fax: __________ Phone: __________ xt: ______ Fax: __________

Send DWC's to *(Please click a check box)*: ☐ **Adjuster** ☐ **Nurse Case Manager**

For Consultations:
Case Manager Consultations: *$250 pre-pay required* / **Case Manager Visit w/ Patient Present:** *$250 pre-pay required*

Bill to: ______________________________
Address: ____________________ City ____________ State ___ Zip Code ________

X______________________________
Case Manager Signature Agreeing to the above
Receipt of this document via email will be considered written authorization from the sender

Fax: 850-398-6855 **Email:** kduke@panhandleortho.com **or** mpastran@panhandleortho.com