PANHANDLE ORTHOPAEDICS

P: 850-784-7724 Option 2 | F: 850-784-7799 | E: workcomp@panhandleortho.com

12909 Panama City Beach Pwy.
Panama City Beach, FL 32407

710 Hospital Drive
Crestview, FL 32539

2401 Langley Avenue Unit B
Pensacola, FL 32504

CONSULTATION REQUEST

TO: Workers' Compensation Department Fax: 850-784-7799

Date: _____

Which Panhandle Orthopaedics clinic would you like to schedule with?

Please click a check box below.

☐ Panama City Beach ☐ Crestview ☐ Pensacola

What state is referral from? _____

How did you hear about us? _____

Please fill out the attached form completely and fax or email to the Workers' Compensation Coordinator of the appropriate location.

Panama City Beach, Crestview & Pensacola Locations - Fax: 850-784-7799 or Email.
Debby Mills: dmills@panhandleortho.com

Documentation required for review prior to scheduling an appointment:

- All op reports and/or diagnostic (to include images on disc)
- Fully completed and signed authorization form
- ALL medical records pertaining to this injury
- Any detailed job description available
- First notice of injury

IMPORTANT- Must Have All Previous Diagnostic Films & Reports

Upon receipt of required documentation, a Work Comp Coordinator will contact you with an appointment date and time.

Please contact us with any questions, comments, or concerns at:

Phone: 850-784-7724 Option 2 **I Fax:** 850-784-7799 **I Email:** workcomp@panhandleortho.com

Email: dmills@panhandleortho.com

Thank you for the referral!

Panhandle Orthopaedics Worker's Compensation Authorization Sheet

Name of Injured Worker: _____DOB:_____
Social Security#:_____ Phone Number: _____
Address: _____ City _____ State ____ Zip Code _____
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? _____

NETWORK: _____ Employer:_____
Address: _____ City _____ State ____ Zip Code _____
Human Resource Contact: _____Phone: _____

PREFERRED VENDOR
DME _____ Diagnostic _____ PT _____

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

☐ Evaluation Only - ***$500 fee for consult*** *(includes x-rays)* ☐ Evaluation and Treatment*

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

If this is a request for one of the following, there is a ***$750 prepayment*** for the consultation *(Click check box below)*.

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

☐ Yes ☐ No MMI Date: _____ PIR % _____ (body as a whole)

☐ MMI/Permanent Impairment Rating Only - ***$500 fee for visit***

All other services* (DME, surgical procedures, advanced imaging, etc. will be requested as needed).
*Services will be rendered by Dr. Gilmore.

Adjuster: _____ NCM: _____
Phone: _____ xt: _____Fax: _____ Phone: _____ xt: _____Fax: _____
Email: _____ Email: _____

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

Bill to: _____
Address: _____ City _____ State ____ Zip Code _____

X _____ Date _____
Case Manager Signature agreeing to the above