ALABAMA ORTHOPAEDIC CLINICS, P.C.

3610 SPRINGHILL MEMORIAL DR. N.
MOBILE, AL 36608

WORKERS' COMPENSATION TREATMENT AUTHORIZATION FORM

Attn: _____

_____

PATIENT: _____

SS#: _____ **INS. CARRIER:** _____

DOI: _____ **EMPLOYER:** _____

CL#: _____ **BODY PART:** _____

CLAIMS BILLING ADDRESS: _____

_____

_____

_____

This letter serves as confirmation that authorization for evaluation & treatment is given for the above named patient. By signing this letter, it is agreed that all services payable to Alabama Orthopaedic Clinics, PC will be reimbursed under the current Alabama fee schedule.

This form must be completed, signed & returned prior to appointment. Failure to do so will result in cancellation of the appointment.

Please Fax Form to 251-410-3735.
If you have any questions please contact the Workers' Compensation Department 251-410-3600.

_____ _____
Accepted by: **Title**

_____ _____
Printed Name: **Company:**

_____
Date: