PANHANDLE ORTHOPAEDICS

P: 850-784-7724 Option 2 | F: 850-784-7799 | E: workcomp@panhandleortho.com
2401 Langley Avenue, Unit B, Pensacola, FL 32504

CONSULTATION REQUEST

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

Date: _____

What state is referral from? _____

How did you hear about us? _____

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

Fax: 850-784-7799
Email: Debby Lentz - dlentz@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 **| Fax:** 850-784-7799 **| Email:** workcomp@panhandleortho.com

Email: dlentz@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 - ***$650 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), Steroid Injection 96372 (as needed). If more than 50 pages, a ***prepay fee of $350*** will be required.

If this is a request for one of the following, there is a ***$900 prepayment*** for the consultation *(Click check box below)*.

☐ One Time Change ☐ Transfer of Care ☐ 2nd Opinion ☐ If more than 50 pages a prepay fee of $350 will be required.

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

☐ MMI/Permanent Impairment Rating Only - ***$550 fee for visit***

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

Cancelation/No-Show Fee: No-show or cancellations within 7 days of appointment for a *One Time Change*, *Transfer of Care*, *2nd Opinion*, or *MMI appointment* will incur a **cancellation / no-show fee of $250**.
Payment of fee will be required before appointment will be re-scheduled.

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 _____
Adjuster or Case Manager Signature agreeing to the above

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