MOVEMENT ORTHOPEDICS

43475 Dalcoma Dr., Suite 250
Clinton Township, MI 48038
Phone: (586) 436-3785 | Fax: (833) 972-5451

Workers' Compensation Referral Authorization Form

Medicals and Diagnostic reports required prior to scheduling

Email: appointments@movementortho.com

Patient Name:		**Date of Birth:**	
Preferred Language:		☐ Male ☐ Female	
Patient Mailing Address:		**Phone #:**	
Patient Email Address:		**Date of Injury:**	
Social Security #:		**Injured Body Part:**	☐ Right ☐ Left ☐ Bilateral
Employer:		**Occupation:**	
Employer Address:		**Phone #:**	

Has this patient received treatment? ***If yes, indicate where (records must be provided)***	**Has surgery occurred?**	☐ Yes ☐ No
Please advise if patient has had any of the following. Check all that apply. ***If yes, reports are required.*** ☐ **X-rays** ☐ **CT** ☐ **MRI**		

Case Manager / Insurance Information

Case Manager Name:	☐ Telephonic ☐ Field	**Phone #:**	
Email Address:		**Fax #:**	
WC Insurance Carrier:		**WC Claim #:**	
Billing Address:		**Jurisdiction:**	
Bill Review Company:		**Telephone/Email:**	
Adjuster Name:		**Email Address:**	
Phone #:		**Fax #:**	
Practitioner and/or Location:			

By signing, you are providing approval for Movement Orthopedics to:

Consultation
Treatment
Labs
X-ray
EMG/NCS
CT Scans
MRI *(scheduled same day as follow-up appointment)*

Physical Therapy — Movement Physical Therapy
All custom splint/braces will be completed by Movement PT as part of patient post-operative care

POST SURGICAL DME: ☐ Yes ☐ No ☐ *(if no, please indicate preferred vendor)*

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Please check who is signing below: ☐ Adjuster ☐ Nurse Case Manager ☐ Employer

Signature	Printed Name / Title	Date