

MicroSpine

AUTHORIZATION FORM WORKER'S COMPENSATION

Patient Name Print: _____

Employer: _____

Claim number: _____

W/C Carrier: _____

DOI: _____

Patient Signature: _____

Date Authorization Requested: _____

To Worker's Compensation Adjuster:

Requesting authorization for the following procedure(s):

Diagnosis

Procedure Code

Evaluations _____

MRI _____

Authorization must be returned with signature prior to scheduling any evaluation, MRI, or procedures with MicroSpine.

All workers' compensation fees for MicroSpine and its entities are based on the Florida Worker's Compensation Fee Schedule. Per Florida Worker's Compensation 2009 Fee Schedule listed procedure and 70% of billed charges for Facility of Non Listed procedures. The employer and/or carrier hereby agree to reimburse MicroSpine based on the aforementioned Florida Worker's Compensation rates within 45 days of receiving the claim.

Date Authorization Granted: _____

Please sign below indicating approval for Evaluation, MRI, or Procedures. MicroSpine will notify you of scheduling and test results of the evaluation, MRI, or procedure(s).

Print Name and Title of
of Authorizing Official

Signature of Official/ Adjuster

Billing Address: _____

Contact Number: _____

Fax Number: _____

Please fax back to Scheduling Department at: 850-892-3765