

OrthoCarolina

Special Exam Checklist

Complete Form & Return with Medical Records & Mandatory Cover Letter

Circle One: IME - One Time Exam CSO – Eval & Treat Transfer of Care

OC DR / LOC _____ DATE _____

OC MR# _____

Appointment Date ____/____/____ Appointment time ____:____AM/P M

Patient Information

Name: _____ DOB ____/____/____

Address: _____ WC Body Part _____

Telephone #: () _____ SS# _____

Employer _____ DOI ____/____/____

Telephone #: () _____

Billing Information

Report/Bill To: _____ Phone: _____

Attention: _____ Fax: _____

Billing Address: _____

Adjuster E-mail Address _____

Person Scheduling: _____ Email Address _____

Telephone #: () _____ Fax #: () _____

NCIC #: _____ Claim# _____

If the patient "No Shows", the appointment isn't cancelled within 24 hours of the appointment date, or the patient arrives for the appointment without all films relating to injury, you will be responsible for a \$250.00 fee. The appointment will be cancelled if the patient arrives without all films relating to the injury.

Date appointment canceled: ____/____/____ Appointment Canceled By: _____

Reason for cancellation: _____

Reschedule date: ____/____/____ Rep/Bill/No Show Letter Sent ____

____ Calendar ____ Confirm Letter ____ Payment Received

____ Patient Letter ____ Invoice Sent