Methodist
McKINNEY HOSPITAL

WORK COMP INTAKE

Appt Date: _____ **Appt Time:** _____ **Account #:** _____

Patient Name: _____ **DOB:** _____ **SSN:** _____

Address: _____

Phone #: _____ **Email:**_____

Employer: _____

Address: _____

Contact Person: _____ **Phone #:** _____

Work Comp Carrier: _____ **Rep:** _____

Phone #: _____ **Fax #:** _____

Claims Address: _____

Adjustor: _____ **Phone #:** _____ **Fax #:** _____

Claim #: _____ **DOI:** _____

Compensable Body Part(s): _____

Diagnosis: _____ **CPT:** _____

Referring Doctor: _____

Pre-Auth Company: _____ **Rep:** _____

Phone #: _____ **Fax #:** _____

Auth/#Visits: _____ **Date Range:** _____

Contacts & Comments

Date: _____ _____

Date: _____ _____

Date: _____ _____

Verified By: _____ **Date:** _____