Work Comp Appointment Form
Fax to: 316-631-1617
Email to: appointments@aoaortho.com
All info must be completed before appointment can be scheduled

AOA - Wichita 2778 N. Webb Rd,
Wichita, KS 67226
316-631-1600
www.AOAortho.com

Account #			
AOA Physician: 1st Available		Is this a **KANSAS** work comp claim: YES	
Patient Name:	**Pt. Phone #**	**DOB:**	**SS #:**
Patient Address:		**Interpreter needed?** NO	
Employer:		**Employer Phone #:**	
Employer Address:		**Employer Fax #:**	
Work Comp Insurance Co.	**Ins. Phone #:**	**Ins. Fax #:**	
Insurance Co. Address			
Adjuster Name:	**Adjuster Fax #:**	**Adjuster Phone #:**	
Claim to be filed with: ☐ **Employer** ☐ **Insurance Company** ☐ **Prism**		**Claim #:**	
Appointment Scheduled by: (Name & Title)		**Phone #:**	
Person Giving Verbal Authorization: ☐ **Employer** ☐ **Insurance Company**		**Referring Physician:**	
Nurse Case Manager:	**Case Mgr. Phone #:**	**Case Mgr. Fax #:**	
What part of body to be treated?		**Date of Injury:**	
Has the patient had surgery? ☐ **No** ☐ **Yes**	**By Whom?**		
List any other previous treating physician:			
Attorney Involved? ☐ **No** ☐ **Yes**	**Attorney Name:**		
Fax Appointment Date Confirm to:			
☐ **Consult*** ☐ **Evaluate/Treat** ☐ **2nd Opinion*** ☐ **IME***			

TO BE COMPLETED BY AOA:

EMERGENT/URGENT: ROUTE TO NURSE: _____ _____
Initials Date

Comments:			
Dr.	**Appointment Date:**	**Time:**	**Check-in time:**
Entered by:	**Date:**		**Chart No.**