Work Comp Appointment Form **Work Comp Demo** **AOA - Advanced Orthopedics Associates**
Fax to AOA - 316-631-1617 **9828 E. Shannon Woods. Ste 100, Wichita, KS 67226**
All info must be completed before appointment can be scheduled **316-631-1600 – www.aoaortho.com**

Account #			
AOA Physician:	Is this a **KANSAS** work comp claim: ☐ YES ☐ NO		
Patient Name:	**Pt. Phone #**	**DOB:**	**SS #:**
Patient Address:	Interpreter needed? ☐YES ☐NO		Sex:
Patient Email:			
Employer:			**Employer Phone #:**
Employer Address:			**Employer Fax #:**
Work Comp Insurance Co.	**Ins. Phone #:**		**Ins. Fax #:**
Insurance Co. Address			
Adjuster Name:		**Adjuster Fax #:**	**Adjuster Phone #:**
Adjuster email:			
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*** ☐ **Prevailing factor**

TO BE COMPLETED BY AOA:

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

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