**Business Name  
TIN-   
NPI-**

**Workers Comp & Auto Verification**

|  |  |
| --- | --- |
| **Patient Name:  Liable Entity Name:** | **Date of Birth:  SSN: \_\_\_\_\_\_\_\_\_\_\_  Date of Injury:** |
| **Adjustor Name:**  **Phone-\_\_\_\_\_\_\_\_\_\_**  **Fax-\_\_\_\_\_\_\_\_\_\_\_\_  Email\_\_\_\_\_\_\_\_\_\_\_\_** | **State of Injury:   Date of Surgery (IA):  Expectation for claim processing:** |
| **Claim #** | **Billing Address:** |
| **Open and Active: Y/N** | **Phone:** |
| **Effective Date:** | **PRIMARY** or **SECONDARY** |

**Network:** IN or OUT

**Network:** IN or OUT

**Deductible:** Ind. / Fam. / **or** WAIVED

**# of visits allowed:** / **or** NO LIMIT

**Is there a visit limit? How many visits have been used this year? \_\_\_\_\_\_** **Any Chiro included?**

How are we sending claims to liable entity? Electronic- Fax- Mail: \_\_\_\_\_\_\_\_\_: PayerID or Fax #

Physician Referral or Order: YES or NO- If yes, who’s the PCP? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior Authorization: YES or NO- If yes, how is auth obtained? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTES: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CALL REFERENCE#: REP NAME:

Employee Printed Name:

Employee Signature: Date: