



AOA - Wichita 9828 E. Shannon Woods, Suite 100
 Wichita, KS 67226
 316-631-1600
 www.AOAortho.com

Work Comp Appointment Form

Fax to: 316-631-1617

Email to: appointments@aoaortho.com

All info must be completed before appointment can be scheduled

Account #									
AOA Physician:					Is this a KANSAS work comp claim:				
Patient Name:			Pt. Phone #		DOB:		SS #:		
Patient Address:					Interpreter needed?				
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?		<input type="checkbox"/> No	<input type="checkbox"/> Yes	By Whom?					
List any other previous treating physician:									
Attorney Involved?		<input type="checkbox"/> No	<input type="checkbox"/> Yes	Attorney Name:					
Fax Appointment Date Confirm to:									
<input type="checkbox"/> Consult*		<input type="checkbox"/> Evaluate/Treat			<input type="checkbox"/> 2 nd Opinion*		<input type="checkbox"/> 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.