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 9828 E. Shannon Woods, Suite 100
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.**