



BIRMINGHAM
NEUROSURGERY
& SPINE GROUP PC

WILLIAM C. WOODALL, III, MD | E. CARTER MORRIS, III, MD | SAMUEL R. BOWEN II, MD | BENJAMIN BANKS FULMER, MD

Workers' Compensation: Initial Office Visit Authorization

Please complete the following Workman's Compensation information and return to our office by fax at least 2 days prior to patient's appointment.

Date of Appointment: _____

Patient Information:

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Alternate Phone: _____

Date of Injury: _____ Claim Number: _____

Worker's Compensation Information:

Carrier Name: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Adjuster Name: _____

Phone: _____ Fax: _____

Case Manager Name: _____

Phone: _____ Fax: _____

Authorization Statement:

This facsimile shall serve as authorization for the above listed patient's initial office visit with Birmingham Neurosurgery & Spine Group, P.C.

Signed: _____ Date: _____