AUTHORIZATION REQUEST FOR MEDICAL SERVICES

BUSINESS AND INDUSTRY

Pardee Emergency Room
800 N Justice St
Hendersonville NC 28791
Phone: (828) 696-1000

Pardee Urgent Care
212-A Thompson St
Hendersonville NC 28792
Phone: (828) 697-3232
Fax: (828) 698-9570

Pardee Urgent Care
2695 Hendersonville Rd
Arden NC 28704
Phone: (828) 651-6350
Fax: (828) 651-6364

Pardee Urgent Care
3334 Bolyston Hwy Suite 10
Mills River NC 28759
Phone: (828) 694-8100
Fax: (828) 694-8101

Todays Date:________________________

Treat for work-related injury: Complaint/Injury: _______________________________ DOI: ____________________

Drug Screen (Check one): ☐ DOT ☐ Non-DOT ☐ No Drug Screen required

☐ Pre-Placement ☐ Post-Accident ☐ Random ☐ For Cause ☐ Promotion

Breath Alcohol Test (Check one): ☐ Pre-Placement ☐ Post-Accident ☐ Random ☐ For Cause

Services Requested (Please check all that apply): Physical: ☐ Pre-placement ☐ DOT ☐ Sports ☐ School

☐ PCP ☐ Audio ☐ PFT ☐ TB Skin Test Vaccine ____________________________________

Other____

EMPLOYER Information (Please complete information and determine address to bill)
Prefill information below:
Employee______________ **Contract Employee**________________ **Temporary Employee**____________________
Company Name:____ **Work Comp Insurance:**______________________________
Mailing Address: ____ **Address:** _______________________________________
City,State, Zip: ____ **City,State, Zip:** __________________________________
Phone: (_______ **)** ______________________________________ **Phone: (** _______ **)** ______________________________
Service Requested/Authorized by: ____
Bill Claim To: ☐ **Company Address as Above** ☐ **Work Comp Insurance Carrier**

***** Please Note***** **The patient will be asked to provide a copy of their personal health insurance cards and information. This will be used in case of denial by the employer or the employer's work comp insurance carrier, as it relates to this service and/or any other services related to this visit. However, the patient will be responsible for any co-pays, deductibles, unpaid or denied charges related to this claim.**

EMPLOYEE - Patient Information Please Print Clearly
Full Name: ____
Medical Insurance: ______________________________________ **Soc Sec Number:** _________________________

Mailing Address: ____ Sex: Male Female

City,State,Zip: ____ **Date of Birth:** _____________________________

Date of Injury : _________________ **Phone: Home (** _______ **)**_____________________ **Cell (** ________ **)**_________________________

Do you have a Primary Care Provider [ ] Yes [ ] No Name:____ **Location:** __________________

Patient/Guardian Signature____ **Date:** _______________________

Note: ***1) All entries must be completed before the patient can be seen. 2) A new authorization form must be completed for each new injury or service. DO NOT complete for Work Comp claims previously authorized. Thank you!***