

WC Authorization Form



Date: _____ WC Date of Injury: _____
Employee: _____ Employee DOB: _____
Employee Address: _____
Employer Occupation: _____ Department: _____
Adjuster: _____ Phone: _____
Email: _____
Nurse Case Manager: _____ Phone: _____
Email: _____
Billing Address: _____
Authorized by Name: _____ Phone: _____
of Authorized Visits: _____ WC Claim #: _____

SERVICES

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Employment Testing | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Early Symptom Intervention _____ | |
| <input type="checkbox"/> Functional Capacity Evaluations | <input type="checkbox"/> Jobsite Analysis _____ | |
| <input type="checkbox"/> WC Conditioning | <input type="checkbox"/> Impairment Rating _____ | |
| <input type="checkbox"/> Certified Hand Therapy | <input type="checkbox"/> Telehealth/Virtual Care | |

To improve speed of scheduling, please send completed forms via email to WCScheduling@urpt.com or via fax to (423) 362-5069.

TO FIND A LOCATION, VISIT URPT.COM/LOCATIONS OR SCAN HERE



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