



Center for  
Orthopaedics  
& Sports Medicine

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COSM Rehab  
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Indiana, PA 15701  
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## WORKERS' COMPENSATION CASE MANAGER/NURSE REVIEWER APPOINTMENT

### Request for Appointment

You have requested to attend an appointment with a patient being seen for a work related injury. To assist with scheduling, we ask that this form be completed and returned to us 72 hours prior to the patient's appointment. We appreciate your cooperation with this process so that we can allocate adequate time for the patient's appointment.

The patient will be required to sign this form on the day of the visit authorizing your attendance. Our charge for attending the appointment is \$100. We will provide a copy of the patient's discharge instructions following the visit. Please complete the following and return to us via fax at **(724) 349-1830**.

Date: \_\_\_\_\_

Case Manager Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Phone Number: \_\_\_\_\_

<b>Patient Name:</b>
<b>Employer Name:</b>
<b>Date of Appointment:</b>
<b>Claim #:</b>

- I will make payment at the time of visit
- Bill my company

*(This section to be completed on the day of the patient's appointment.)*

### AUTHORIZATION FOR NURSE REVIEWER TO ATTEND PATIENT VISIT WITH PROVIDER

- I authorize** the case manager/nurse reviewer to attend the above appointment with me as it relates to the work injury for which I am currently being treated. A copy of the visit form will be given to the nurse reviewer at the time of my visit.
- I do not authorize** the case manager/nurse reviewer to attend my appointment.

\_\_\_\_\_  
Patient Signature (required)

\_\_\_\_\_  
Date

- Copy to Billing Dept.