**Authorization for Physical Therapy/Occupational Therapy**

Date:

To: Fax#

Attn: Phone#

PATIENT’S NAME: DOB:

Patient Address

Patient Phone # Patient of:

Claim #: Date of Injury:

It is our policy that authorization from the worker’s compensation carrier be received in our office prior to the scheduled appointment. All fees are to be reimbursed at the CT Worker’s Compensation Fee Schedule. For your convenience, please sign and return this notice via fax

to 860-652-8411 or via email to: mtorres@thehandcenteronline.com, as **authorization for Physical Therapy/Occupational Therapy**. If you have any questions, please contact the office.

**Eval Only** (please circle): **PT OT** valid from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eval & Treat:**

**Physical Therapy Visits Allowed**: \_\_\_\_\_\_\_\_

**Occupational Therapy Visits Allowed**: \_\_\_\_\_\_\_\_

Body Part: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Workers’ Compensation Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjuster Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjuster Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization Signature: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Printed name of person signing the Authorization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Very truly yours,

The Hand Center

195 Eastern Blvd., Ste. 200

Glastonbury, CT 06033

Attn: Harra

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