OrthoCarolina Special Exam Information Form – Fax To: 704-945-7684

PLEASE READ CAREFULLY AND CHECK THE APPROPRIATE SPECIAL EXAMINATION

○ **IME** –. *Is a Independent Medical Evaluation, without treatment.* ***This exam is for the physician's opinion ONLY.***

○ **CSO** – The CSO requires a review of all medical records, x-rays and all other diagnostic studies. It is generally requested to determine the appropriateness of a proposed surgical procedure. The patient is required to bring in all x-rays, CT scans and/or MRIs. ***This exam is for the physician's opinion ONLY.***

○ **CSO WITH TRANSFER OF CARE** - The requesting party authorizes total and complete transfer of care.

****PLEASE NOTE When forwarding the medical chart, ONLY INCLUDE the Office Visit Notes, Physician Correspondence, and Diagnostic Test Results pertaining to the requested exam. Please DO NOT include attorney correspondence and PT Notes.**

PATIENT INFORMATION TO BE COMPLETED BY THE REQUESTING PARTY

NAME: _____ **DOB:** _____ **SSN:** _____

ADDRESS: _____ **CITY:** _____**STATE:** _____ **ZIP**_____

PHONE_____

EMPLOYER: _____ **PHONE**_____

ADDRESS: _____ **CITY:** _____**STATE:** _____ **ZIP**_____

BILLING INFORMATION TO BE COMPLETED BY THE REQUESTING PARTY

REPORT/BILL TO: _____ **PHONE:** _____

ATTENTION: _____**FAX:** _____

CLAIMS ADDRESS: _____**CITY**_____**STATE**_____**ZIP**_____

ADJUSTER'S EMAIL ADDRESS: _____

JURISDICTION OF CLAIM_____ **CLAIM#**_____

PERSON SCHEDULING: _____**FAX:**_____**PHONE:**_____

BODY PART INJURED: _____ **DATE OF INJURY:**_____

EMAIL: _____

ADJUSTER/ ATTORNEY/ AUTHORIZATION SIGNATURE: _____

DATE:_____/_____/_____

ORTHOCAROLINA USE ONLY

TODAY'S DATE: _____/_____/_____ **OC MRN #** _____ **OC PHYSICIAN:**_____

APPT. DATE: _____/_____/_____ **APPT. TIME/LOCATION:** _____

DATE APPOINTMENT CANCELLED: _____/_____/_____

REASON FOR CANCELLATION: _____

INVOICE SENT ON: _____/_____/_____

PAYMENT RECEIVED ON: _____/_____/_____ **CHECK NUMBER**_____