SPORTS MEDICINE
Texas Metroplex Institute for Sports Medicine & Orthopedics

WWW.TMISportsmed.com

Thank you for your interest in having your workers' compensation case reviewed by our doctors. Please note that if you are not part of the Alliance Network, we may not be able to accept your case.

To review your case, we require **all medical records related to your injury**, including doctor's notes, MRI and X-ray images on a disc, imaging reports, ER notes, and operative reports if applicable. Unfortunately, diagnostic images cannot be faxed or emailed.

Once we have received all records and the completed information below, we will review your case and contact you with our decision. Thank you.

Please complete the information below fully so we can process your case efficiently**:**

Name of patient:

DOB:

SS#:

Phone #:

Email:

Claim #:

Date of Injury:

Compensable Injury (body part):

Completed Diagnostic Testing:

Are there any disputes on the claim?

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Employer Name:

Address:

Phone:

Fax:

Adjustor Name:

Phone:

Email:

Fax:

Insurance Company:

Name:

Claims Address:

Phone:

Fax:

Utilization review Company:

Address:

Phone:

Fax:

Where do we send the work status forms?

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For Adjuster or Office Use Only:

Do we have Reasonable and Necessary for Evaluation and Treatment?

_____ Yes, approved by:_____

_____ No, patient is not approved to come to TMI

Scan documented authorization into the chart

Approved Medical Provider:_____Date/Time: _____

# of visits approved: _____

Scheduled By:_____