

MEDICAL AUTHORIZATION



ILLINOIS
BONE & JOINT
INSTITUTE®

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JOINT INSTITUTE

| | |
|------------------------------------|----------------|
| Patient Name: | Today's Date: |
| Employer Name: | Phone: |
| Authorized by: | Body Part: |
| WC Claim #/Carrier (if available): | Send Bills To: |

FOR WORK RELATED INJURY: CHECK ALL THAT APPLY

| | |
|---|--|
| <input type="checkbox"/> Office Visit/Injury Evaluation | <input type="checkbox"/> CT Scan |
| <input type="checkbox"/> X-Ray | <input type="checkbox"/> PT/OT |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Work Conditioning |
| <input type="checkbox"/> Pre-Employment/POET Testing | <input type="checkbox"/> Pain Management |

SEND TO SPECIALSERVICES@IBJI.COM
FOR MORE INFORMATION VISIT US AT IBJI.COM/EMPLOYERS
844-425-4669

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