

# Protocol for Submitting WRS Prescriptions

Please choose from one of the three ways to submit your qualified workers' compensation, commercial, or Medicare patient orders to WRS.

## 1 Use your own surgical order form (AKA patient demographics, face sheet)

A complete order must contain all information listed below. If you are utilizing your surgical order form and it does not already contain the information listed below, please hand write in the missing information.

- ✓ Patient Name
  - ✓ Claim Number
  - ✓ ICD-10 Code(s)
  - ✓ Insurance Carrier
  - ✓ DOB
  - ✓ DOS or Non-Op
  - ✓ DOI\*
  - ✓ Adjuster Name & Phone Number\*
- \*Not required but is helpful\*

## 2 Fillable WRS 1Form

Please select if the prescription is for CCT or Proventus Recovery.

Please **type** in all necessary information listed on the WRS 1Form

## 3 Physical WRS 1Form

Please select if the prescription is for CCT or Proventus Recovery.

Please **write** in all necessary information listed on the WRS 1Form.

## For All Orders:

- If your state requires state specific authorization forms please submit along with the information requested above.
- Physician signature or e-signature is required on all orders and state forms.
- Please fax all orders to **(888) 829-0065** or email **admin@wrspecialists.com**



WRS

1Form



Cold Compression Therapy

(Please check)

Please submit all information possible.  
The required fields are in bold

PROVENTUS RECOVERY

(Please check)

**Date of Surgery:** \_\_\_\_\_ Non Operative:

**Patient Name:** \_\_\_\_\_ **Male:**  **Female:**  **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_  
City State Zip

**DOI:** \_\_\_\_\_ **Insurance Carrier:** \_\_\_\_\_

Insurance Address: \_\_\_\_\_ **Phone #:** \_\_\_\_\_  
City State Zip

**Claim # / SSN #:** \_\_\_\_\_ **Adjuster Name:** \_\_\_\_\_

Adjuster Email: \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

NCM Name: \_\_\_\_\_ **NCM Phone:** \_\_\_\_\_

Employer Name: \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Left:**  **Right:**  **Bilateral:**  **ICD-10 Code:** \_\_\_\_\_

Diagnosis: \_\_\_\_\_ **Treatment Site:** \_\_\_\_\_

**Physician:** \_\_\_\_\_ **NPI #:** \_\_\_\_\_

Physician Address: \_\_\_\_\_  
City State Zip

## How to Submit:

F: (888) 829-0065

E: admin@wrspecialists.com

**Questions? Please call 734-492-5962**