EXPERCARE

WORKER'S COMPENSATION AUTHORIZATION FORM

Rincon	Hinesville	Statesboro	Savannah Mall Blvd	Richmond Hill	Savannah Downtown	Pooler
463 S. Columbia Ave	632 W. Oglethorpe Hwy	121 Tormenta Way	318 Mall Blvd.	60 Exchange Street	818 Abercorn Street	2201 Pooler Parkway
Rincon, GA 31326	Hinesville, GA 31313	Statesboro, GA 30458	Savannah, GA 31406	Richmond Hill, GA 31324	Savannah, GA 31401	Pooler, GA 31322
912.812.1001	912.430.4545	912.680.0020	912.358.1515	912.756.2273	912.800.0110	912.800.6004
Fax: 833.973.5094	**Fax: 833.973.5091**	**Fax: 833.973.5096**	**Fax: 833.973.5092**	**Fax: 833.973.3562**	**Fax: 833.973.5090**	**Fax: 833.973.5093**
8 am – 7 pm weekdays	8 am – 7 pm weekdays	8 am – 7 pm weekdays	8 am – 7 pm weekdays	8 am – 7 pm weekdays	8 am – 7 pm weekdays	8 am – 7 pm weekdays
8 am – 4 pm weekends	8 am – 4 pm weekends	8 am – 4 pm weekends	8 am – 4 pm weekends	8 am – 4 pm weekends	8 am – 4 pm weekends	8 am – 4 pm weekends

EMPLOYER INFORMATION

COMPANY NAME:

ADDRESS:

CITY

STATE

AFTER HOURS/EMERG

AFTER HOURS/EMERG

ENCY NAME:

:NCY PHONE:

CONTACT FOR AUTHORIZATION:

MAIN PHONE:

CELL PHONE:

FAX:

EMAIL:

ZIP

Employee Name

Employee DOB

Employee SSN

Work Comp Carrier:

WC Claim Number:

Case injury date:

Injured body part:

#N/A

Adjuster last name

Adjuster first name

Adjuster phone

Adjuster email

Date of Service:

Reason for Visit:

Diagnosis Code(s):

PLEASE SELECT ALL SERVICES THAT YOU AUTHORIZE TO BE PERFORMED:

☐ New WC- Evaluate and Treat ☐ Return WC- Evaluate and Treat ☐ Post Accident Drug Screen ☐ DOT Drug Screen

☐ Other Services: _____

SPECIAL NOTES AND INSTRUCTIONS: _____

This form will serve as your authorization to perform the selected procedures and tests on your employee. Please sign and date below. Please contact us if you have additional requests not shown on this list or if you have further questions or instructions. It's a pleasure to serve your Occupational Health needs.

I understand I am requesting treatment for the above mentioned individual for a work-related incident. If I do not provide a claim number within 7 days of the treatment date, I understand that all cost will be the responsibility of the company to pay.

Signature of Company Representative

Printed Name

Date