Worker's Compensation Authorization Form

EXPERCARE

Employer Information

Company Name:

Address:

City:

State: Zip:

Contact for Authorization:

Main Phone:

Cell Phone:

Fax:

Email:

After Hours/Emergency Name:

After Hours/Emergency Phone:

Employee Name:

Employee DOB:

Employee SSN:

Date of Service:

Work Comp Carrier:

WC Claim Number:

Case Injury Date:

Injured Body Part:

PLEASE SELECT ALL SERVICES THAT YOU AUTHORIZE TO BE PERFORMED:

- ☐ New WC - Evaluate and Treat
- ☐ Return WC - Evaluate and Treat

Drug Screenings (DOT)

- ☐ DOT Drug Screen (ExperCARE COC)
- ☐ DOT Drug Screen (Use your own COC)
- ☐ Breath Alcohol DOT

Drug Screenings (Non-DOT)

- ☐ Instant 5 Panel (Confirmation Testing Included)
- ☐ Instant 12 Panel (Confirmation Testing Included)
- ☐ Send Out 5 Panel using ExperCARE COC
- ☐ Send Out 10 Panel using ExperCARE COC
- ☐ Collection Only (company use own paperwork/coc/instructions)
- ☐ Breath Alcohol NON-DOT

☐ 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