

Worker's Compensation Authorization Form



Bill to Employer

Bill to Work Comp Carrier

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