

550 30th Ave, Suite 12 Moline, IL 61265

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**Worker’s Compensation Medical Treatment Authorization Form**

**(Injury)**

This authorization is to provide medical services to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print Patient Name)

DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Authorizer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Authorizer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax or Mail results to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Auth Received by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section D: Authorization Information**

**Section A: Employer Information**

Employer Name:

Address:

Phone #:

Fax #:

Is Alternative Work available?

* Yes
* No

**Insurance Carrier**

Name:

Address:

Claim #:

If not available, has claim been reported?

* Yes
* No

Adjuster Name:

Phone #:

Fax #:

**Section B: Patient Injury Information**

Injured body part(s):

Date of Injury:

**Section C: Urine Drug/Alcohol Tests**

Urine Drug Screens

* Collection only

Drug Free Workplace

* 5 Panel HRS
* 8 Panel HRS
* 10 Panel HRS

DOT

* DOT/NIDA

**Alcohol Testing**

* Non-DOT Breath Alcohol Test
* DOT Breath Alcohol Test

Additional Comments: