ADE MEDICAL GROUP
550 30th Ave, Suite 12 Moline, IL 61265
Ph (309) 762-5513 F (309) 762-5519

# Worker's Compensation Medical Treatment Authorization Form (Injury)

This authorization is to provide medical services to: _____
(Print Patient Name)

DOB _____ SS# _____

**Section A: Employer Information**

Employer Name:

Address:

Phone #:

Fax #:

Is Alternative Work available?
- o Yes
- o No

**Insurance Carrier**

Name:

Address:

Claim #:
If not available, has claim been reported?
- o Yes
- o 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
- o Collection only

Drug Free Workplace
- o 5 Panel HRS
- o 8 Panel HRS
- o 10 Panel HRS

DOT
- o DOT/NIDA

**Alcohol Testing**
- o Non-DOT Breath Alcohol Test
- o DOT Breath Alcohol Test

Additional Comments:

**Section D: Authorization Information**

Print Name of Authorizer: _____ Authorizer Signature: _____

Title: _____ Phone #: _____ Date: _____

Fax or Mail results to: _____
Billing Address: _____
Phone Auth Received by: _____ Date/Time: _____


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**Worker's Compensation Authorization**

Today's Date: _____

Employee: _____

Employer: _____

Supervisor: _____

Date of Accident: _____

WC Insurance Carrier: _____

Adjuster/Agent: _____

Authorized by Telephone on: _____ With: _____

Specific Instructions: _____

_____

_____

_____

The above-named employee has reported to our office for medical treatment due to injuries sustained while on the job. Please sign this authorization for treatment and return it to our office along with a completed copy of the **Employee's Injury Report**. Thank you for your assistance.

Signature: _____

Title: _____

Note: According to L.C. Section 4600, the employer is required to inform all injured employees of their rights and benefits with respect to medical treatment.