Workers' Compensation Medical treatment Authorization Form (INJURY)

DIRECTIONS: Complete all Sections A - D Entirely
(Only services marked on this form will be completed)

**** ALL services require photo identification to be provided by employee at time of service.**

This is authorization to provide medical services to:____ **DOB:**________________ **SSN:**____________________

(Print Patient Name Above)

Section A: Employer Information	Section B: Patient Injury Information	Additional Comments / Notes:
Employer Name:	Injured Body Part(s):	
Address:		
Phone #	Date of Injury:	
	Section C: Urine Drug / Alcohol Tests	
Fax #	**Urine Drug Screens** ◯ Collection Only / Donor will bring COC	
Insurance Carrier	**Florida Drug Free Workplace** ◯ 5 Panel HRS ◯ 8 Panel HRS ◯ 10 Panel HRS	
Name: Address:		
Claim # If not avaliable has claim been reported ◯ YES ◯ NO	**DOT** ◯ DOT / NIDA	
Adjuster Name:	**Alcohol Testing (LKE, APL, NTH & MHN ONLY)**	
Fax #	◯ DOT Breath Alcohol Test ◯ Non - DOT Breath Alcohol Test	
Phone #		

Section D: Authorization Information		
Print Name of Authorizer:	Authorizer Signature: ___________________________________	Phone #
	Title:	Date:
Fax or Mail results to:	Billing Address:	**For Patients First Use Only:** Phone Auth received by:
		Date & Time:

December 7, 2017

Patients First Fax Numbers:

Lake Ella -- 850-385-6838
Kerry Forest -- 850-668-3226
Raymond Diehl -- 850-701-0885
Parkway -- 850-681-2848
Mahan -- 850-656-1391
Appleyard -- 850-576-8153
North Monroe -- 850-562-4460