

# TREATMENT AUTHORIZATION

We are authorizing the below listed U.S. HealthWorks location to provide services to our employees:

## U.S. HEALTHWORKS MEDICAL GROUP LOCATED AT:

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

FAX: \_\_\_\_\_

COMPANY NAME: \_\_\_\_\_

EMPLOYER#: \_\_\_\_\_

PRIMARY CONTACT NAME: \_\_\_\_\_

PH: \_\_\_\_\_

PH (after HRs/Cell): \_\_\_\_\_

EMAIL: \_\_\_\_\_

EMPLOYEE DETAILS

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_ AM OR \_\_\_\_\_ PM

PATIENT NAME: \_\_\_\_\_

DEPARTMENT: \_\_\_\_\_

DOES EMPLOYEE WORK FOR A TEMP/LEASING COMPANY? YES NO NAME OF TEMP AGENCY: \_\_\_\_\_

AUTHORIZED BY: NAME (PRINT): \_\_\_\_\_

PHONE: \_\_\_\_\_

TITLE: \_\_\_\_\_

AFTER HRS / CELL PH: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

( ) VERBAL

INSURANCE

INSURANCE COMPANY NAME: \_\_\_\_\_

CLAIMS ADDRESS: \_\_\_\_\_

PHONE#: \_\_\_\_\_

EFFECTIVE DATE: \_\_\_\_\_

POLICY #: \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_

SERVICES

INJURY: DATE OF INJURY: \_\_\_\_\_

LAST WORKED: \_\_\_\_\_

INJURED BODY PART: \_\_\_\_\_

CLAIM #: \_\_\_\_\_

RETURN-TO-WORK EVALUATION \_\_\_\_\_

PHYSICAL EXAM TYPE: \_\_\_\_\_

PROTOCOL #: \_\_\_\_\_

DRUG/ALCOHOL TEST. SPECIFY TYPE AND REASON/PURPOSE BELOW \_\_\_\_\_

PROTOCOL # \_\_\_\_\_

### TYPE:

DOT DRUG TEST                      DOT BREATH ALCOHOL TEST  
NON-DOT DRUG TEST                NON-DOT BREATH ALCOHOL TEST  
INSTANT CHECK TEST

### REASON/PURPOSE:

PRE-EMPLOYMENT                      REASONABLE SUSPICION  
POST-ACCIDENT                        RANDOM  
RETURN TO DUTY                        POST-INJURY

**NOTE: PICTURE ID REQUIRED FOR DRUG TESTING**

***Thank you for choosing U.S. HealthWorks Medical Group!***