TREATMENT AUTHORIZATION

Employee Name: ________________________________ Date: __________________

Date of Injury: _____________________ Type of Injury: ________________________

Employer: ________________________ Phone: _____________________________

Address: ____

Authorized by: ___________________ Signature: ____________________________

Workers Comp Carrier: ____

Address: ____

Phone: _________________________________ Policy Number: _________________

Adjuster: _____________________________ Claim Number: ___________________

Post-Accident Drug Screening: _________ Instant Drug Screen: ______________

Nida: _____ Non-Nida: _____ Urine Alcohol (Can Only Be Done With Non-Nida):_____

Our Lab: _________ Collection Only (Your Chain of Custody Form): _________________

1. Employer Agrees to file all first reports to their comp provider immediately.
2. First Aid claims payable in 30 days from the date of service.
3. Notify Med Care Medical of any changes in your workers comp policy.

Comments: ____

FAX (916) 783-6049 1907 Douglas Blvd, Suite 70, Roseville, CA 95661 Phone (916) 783-0101