MEDCARE+
MEDICAL CENTER

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:_____

_____

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