WorkersCare

Phone# 770-479-4777 Fax# 770-479-9491

Authorization for Treatment

Patient Name ______________________________________DOB_________________________

Address____

Home Phone#________________________Work Phone#___________________________

SS#________________________________ Date of Injury____________________________

Reason for Visit____

Employer:_____________________________ Contact Person:_________________________

Phone# ______________________ Fax# ______________________

Address: ____

Drug Screen Required: Y N 5 Panel / 10 Panel / Laboratory

Bill Employer___________ **Bill Insurance**___________

Insurance Company Name: ____

Address: ____

Phone#: ___________________ Fax#: ________________________

Adjustor Name: ___________________________ Claim#_______________________

Comments____
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WorkersCare is authorized to evaluate and treat the above referenced patient. As the employer, we and/or our insurance company agree to pay for services incurred by the above referenced patient.

Treatment Authorized By: ___________________________