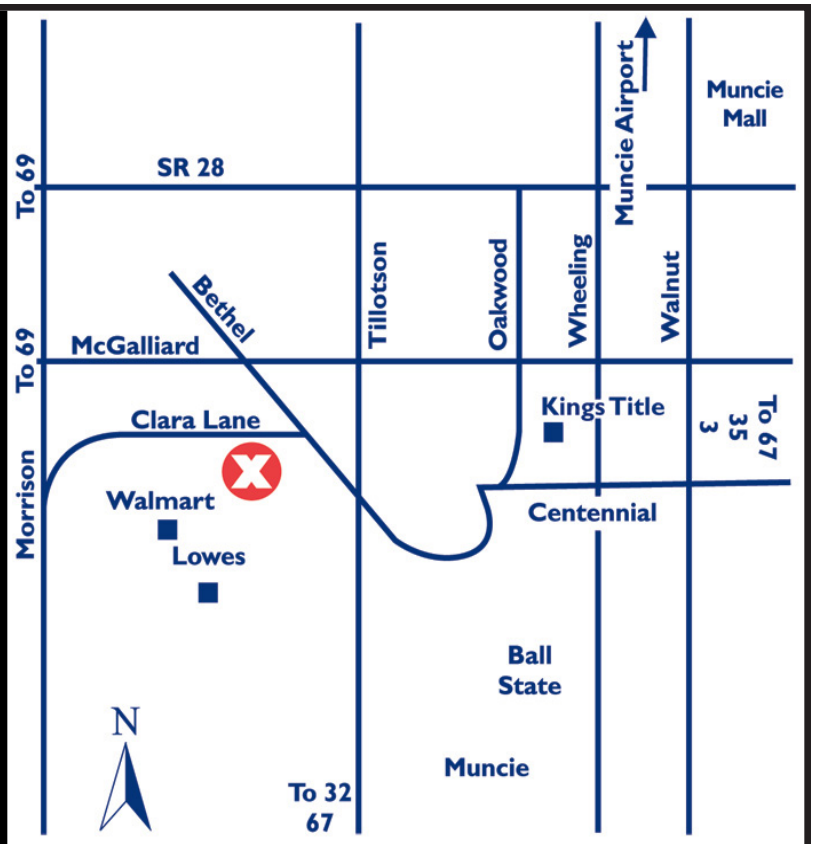
TREATMENT AUTHORIZATION

U.S. HealthWorks MEDICAL GROUP
The Right Care, Right Away

[redacted]
3911 West Clara Lane
Muncie, IN 47304
PH: (765) 288-8800
FX: (765) 751-2278
Mon-Fri: 8:00 am - 7:00 pm, Sat-Sun: 8:00 am - 6:00 pm



COMPANY NAME _____ EMPLOYER # _____

PRIMARY CONTACT NAME _____

ADDRESS LINE 1 _____

ADDRESS LINE 2 _____

CITY _____ STATE _____ ZIP _____

FAX _____

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

REASON/PURPOSE:

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

PICTURE ID REQUIRED

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