

Treatment Authorization Form

Employee Name: Company Name: Company Name: Company Phone #: Questions to (Print Name): Ph. #:	Date:	Employee SSN (Last 4):	Person A	Person Authorizing Treatment:	
Company Phone #: Ph. #: The employer requesting service is responsible for payment in cases of denial or first aid determination. Group Treatment Authorization Group Treatment Auth	Employee Name:	DOB:	<u> </u>		
Services Request Services Request Services Request Check each requested medical service Group Treatment Authorization Group Treatment Authorizatio	Company Name:		Ph:	Fx:	
Services Request Check each requested medical service Single Treatment Authorization Safety Training Basic Medical Exam Types Basic Medical Exam Types Basic Medical Exam Types Worker Compensation Injury Treatment Treatment of Industrial Injuries Worker's Compensation requires full SS# SS#: Worker's Compensation requires full SS# SS#: Worker Start Training Sypervisor Drug and Alcohol Awareness SS#: Workers' Lompensation requires full SS# SS#: Workers' compensation requires full SS# SS#: Supervisor Drug and Alcohol Awareness Sypervisor Drug and Alcohol Awareness Sypervisor Drug and Alcohol Awareness Workers' compensation requires full SS# SS#: Workers' compensation requires full SS# SS#: Workers' compensation requires full SS# SS#: Safety Training Cardiopulmonary Resuscitation (CPR) First Alu Training Supervisor Drug and Alcohol Awareness Sypervisor Drug and Alcohol Awareness Sypervisor Drug and Alcohol Awareness Ser: Workers' compensation requires full SS# SS#: Cardios Drug Treatment Authorization Name (First, Last) DOB SS# (Last 4) Workers' compensation requires full SS# Symptosor Drug and Alcohol Awareness Symptosor Drug and Alcohol Awareness Ser: Workers' compensation requires full SS# Symptosor Drug and Alcohol Awareness Special Requires First Alu Training Cardiopulmonary Resuscitation (CPR) First Alu Training Supervisor Drug and Alcohol Testing DOB SS# (Last 4) Workers' compensation requires full SS# Symptosor Drug and Alcohol Testing DOB SS# (Last 4) Name (First, Last) NoTE: For groups larger than 4, please request our additional authorization group form. Special Requires Special Requires NoTE: F	Company Phone #:		Email:		
Services Request Check each requested medical service Single Treatment Authorization Medical Exam Types Basic Medical Physical Exam DMV/DOT Medical Exam Place Main Physical Exam Pre-Employment Reason for Field Physical Exam Pre-Employment Reason for Fields Pre-Employme	• • •	Ph. #:	for payment in cases of denial or first aid		
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