RANCHO PASEO
MEDICAL GROUP
Total Family Care

Medical Treatment Authorization

Date: _____

Employer: _____

Supervisor Name: _____

Phone: _____

Confidential Fax: _____

Address: _____

Carrier: _____

Adjuster: _____

Phone: _____

Fax: _____

Billing Address: _____

Authorization is given for the following treatment:

☐ Work Injury on _____ (date of injury)

YES / NO First Report Included: _____

YES/NO Claim Number: _____

YES/NO Is Modified Work Available? _____

☐ Pre-Employment Physical
Special Instructions (i.e. DMV physical): _____

☐ Drug Screen (5 Panel urine collection will be performed if other not specified)
Special Instructions: _____

☐ X-RAYS (specify): _____

☐ Other: _____