



264 N. Highland Springs Ave. 5A. Banning, Ca 92220  
phone: 951.769.0079 fax: 951.845.6750

### Medical Treatment Authorization

Date: \_\_/\_\_/\_\_

#### Patient

Name: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_

#### Employer

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Contact number: \_\_\_\_\_

#### Insurance Carrier

Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Group Adjuster: \_\_\_\_\_ Phone: \_\_\_\_\_

#### Injury

Nature: \_\_\_\_\_ Date: \_\_/\_\_/\_\_

Claim Number: \_\_\_\_\_

#### Authorization

Authorization is given for the following:

- Drug Screen instant
- Drug Screen (*Lab COC needed for send out and provided by employer*)
- Physical exam:  Pre-Employment  DOT/DMV  Return-to-duty
- TB Screening
- X-Rays: \_\_\_\_\_
- Other: \_\_\_\_\_

Signature of Employer Representative: \_\_\_\_\_