Date:

WORKERS COMPENSATION

Medical Authorization & New Account Set Up

Authorization to provide medical care to:

If injured, describe injury / illness:

EMPLOYER INFORMATION

COMPANY NAME:	PHONE:
CONTACT FOR AUTHORIZATION:	CELL PHONE:
ADDRESS:	EMAIL:
	FAX:
CITY:	AFTER HOURS/EMERGENCY NAME:
STATE: ZIP:	AFTER HOURS/EMERGENCY PHONE:

WORKERS COMP BILL TO:

(CHECK ONE) EMPLOYER *(skip this section)* W/C INSURANCE CARRIER OTHER

NAME OF INSURANCE CARRIER:	
ADDRESS:	CONTACT NAME:
	PHONE:
CITY:	FAX:
STATE: ZIP:	EMAIL:

WORKERS COMP THIRD PARTY ADMINISTRATOR BILL TO:

NAME OF THIRD PARTY ADMINISTRATOR:	
ADDRESS:	PHONE:
	FAX:
CITY:	EMAIL:
STATE: ZIP:	CONTACT NAME:

WORKERS COMP DRUG SCREEN INSTRUCTIONS:

Do you require a post-accident drug screen?	YES	NO
Will it be a DOT drug screen?	YES	NO
If non-DOT, in house 11 panel (instant result)	YES	NO
If non-negative, send for MRO (confirmation)?	YES	NO
Chain of Custody Form provided by:	Employer	UCCRH

Drug Screen should be billed to:

Employer WC Ins. WC Third Party Admin

Drug Screen results should be communicated: Immediately / Via Mail

Contact:

Phone #:

Secure Fax #:

Or (Call # to secure fax line before sending)

GENERAL WORKERS COMP INSTRUCTIONS:

When being sent to our clinic to be evaluated you will give authorization by:

Phone Fax (912) 756-3773 Email (reception@theucconline.com) Patient will bring authorization form

If patient needs to be referred to specialist, who can give approval?

OTHER NOTES / INSTRUCTIONS:

*Please see our Occupational Health form for more employer paid services such as pre-employment physicals, DOT physicals, drug screens, xrays, etc.