TREATMENT AUTHORIZATION

We are authorizing the below listed location to provide services to our employees:

LOCATED AT:

ADDRESS:

PHONE:

FAX:

COMPANY NAME: EMPLOYER #:

PRIMARY CONTACT NAME:

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: Athens Administrators

CLAIMS ADDRESS: P.O. Box 696, Concord, CA 94522

PHONE: 866-482-3535 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

NOTE: PICTURE ID REQUIRED FOR DRUG TESTING

Thank you!