Emerald Coast Family Physicians

4785 N. 9th Ave. Pensacola, FL 32503

Worker's Compensation Medical Treatment Authorization Form (INJURY

**All services require photo identification to be provided by employee at time of service

DIRECTIONS: Complete all Sections A – D entirely

This is authorization to provide medical services to: _____DOB: _____SS#_____ Date:_____

(Print Patient Name Above)

Section A: Employer Information
Employer Name:
Address:
Phone:
Fax:
Is alternative work available? Yes or No
Insurance Carrier
Name:
Address:
Claim Number: If not available has the claim been reported to the insurance carrier? Yes or No
Adjuster Name:
Fax:
Phone:

Section B: Patient Injury Information
Injured Body Part (s):
Date of Injury:
Section C: Urine Drug Testing
Urine Drug Screens (Please circle one if you require a drug screen) • Collection Only (Please have the employee bring in the company's COC) • In House NON-DOT drug screen (On our clinic's COC) • DOT drug screen (Work free workplace as the MRO) • No drug screen is required ** Your company will be responsible for the full price of the drug screen. This charge is NOT filed through the Workman's Comp carrier on a HCFA 1500 claim form. You will receive a statement for the drug screen charge separately.
Additional Comments/Notes:

Section D: Authorization information
I authorize Emerald Coast Family Physicians to provide medical treatment to the patient listed above. Please report your employee's accident to your Worker's Compensation Carrier. Also, please provide our office with a copy of the Notice of Injury within 24 hours of the accident date. If the above information is not received and reported to your insurance carrier, payment for services will be due in 10 days.
Print Name of Authorizer:
Authorizer Signature:
Title:
Billing Address:
Phone:
Fax:
Email:
Where to fax or mail drug screen results to: