TREATMENT AUTHORIZATION

U.S. HealthWorks®
MEDICAL GROUP
A Dignity Health Member

We are authorizing the below listed U.S. HealthWorks(s) to provide treatment to our employees. By doing so, we acknowledge that if the claim is denied by our insurance carrier, we will notify USHW of the denial and will be responsible for payment for all services rendered and any medically-necessary items dispensed.

U.S. HEALTHWORKS MEDICAL GROUP LOCATED AT:

ADDRESS: ____________________

PHONE: ____________________ FAX: ____________________

EMPLOYER

EMPLOYER NAME: ____________________ EMPLOYER# (if applicable): ____________________

EMPLOYER ADDRESS: ____________________ PRIMARY CONTACT NAME: ____________________

PHONE: ____________________ AFTER HRS / CELL PHONE: ____________________

FAX: ____________________ EMAIL: ____________________

EMPLOYEE DETAILS

PATIENT NAME: ____________________ DATE: __________ TIME: __________ AM / PM

DEPARTMENT: ____________________ POSITION: ____________________

DOES EMPLOYEE WORK FOR A TEMP/LEASING COMPANY? YES NO NAME OF TEMP AGENCY: ____________________

AUTHORIZED BY: NAME (print): ____________________ PHONE: ____________________

TITLE: ____________________ AFTER HRS / CELL PHONE: ____________________

SIGNATURE: ____________________ ( ) VERBAL AUTHORIZATION

INSURANCE

INSURANCE COMPANY NAME ____________________

CLAIMS ADDRESS: ____________________

PHONE: ____________________ 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
  Agency (required): ____________________
- ❑ DOT BREATH ALCOHOL TEST
- ❑ NON-DOT DRUG TEST
- ❑ NON-DOT BREATH ALCOHOL TEST
- ❑ INSTANT DRUG TEST

REASON/PURPOSE:

- ❑ PRE-EMPLOYMENT
- ❑ RANDOM
- ❑ REASONABLE SUSPICION
- ❑ POST-ACCIDENT
- ❑ RETURN TO DUTY
- ❑ FOLLOW UP
- ❑ POST-INJURY

Perform test before: Date: __________ Time: __________ AM / PM

*** PICTURE ID REQUIRED FOR DRUG TEST**

U.S. HealthWorks