

25431 Cabot Rd. • Suite 118, Laguna Hills, CA 92653 • (949) 362-8877 • Fax: (949)362-9230

TREATMENT AUTHORIZATION

Patient Name _____
 Date of Injury _____ Date Patient Sent _____
 Employer _____
 Contact _____
 Phone Number a.m. _____ p.m. _____
 Insurance Carrier _____
 Insurance Phone Number _____
 Authorization of Treatment _____

SIGNATURE OF SUPERVISOR

SERVICES REQUESTED

First Aid Only

Treatment of Injury Physical Exams

With Drug Screen Pre-Placement

With Breath Alcohol Return to Work

Non-Work Related D.O.T.

Other _____ Other _____

Drug Screening Non-Federal Federal Profile II

Probable Cause Post Accident

Random Other _____

Modified Work Available? Yes No

Bill Employer? Yes No

Bill Insurance? Yes No

Work with Temp Agency? Yes No

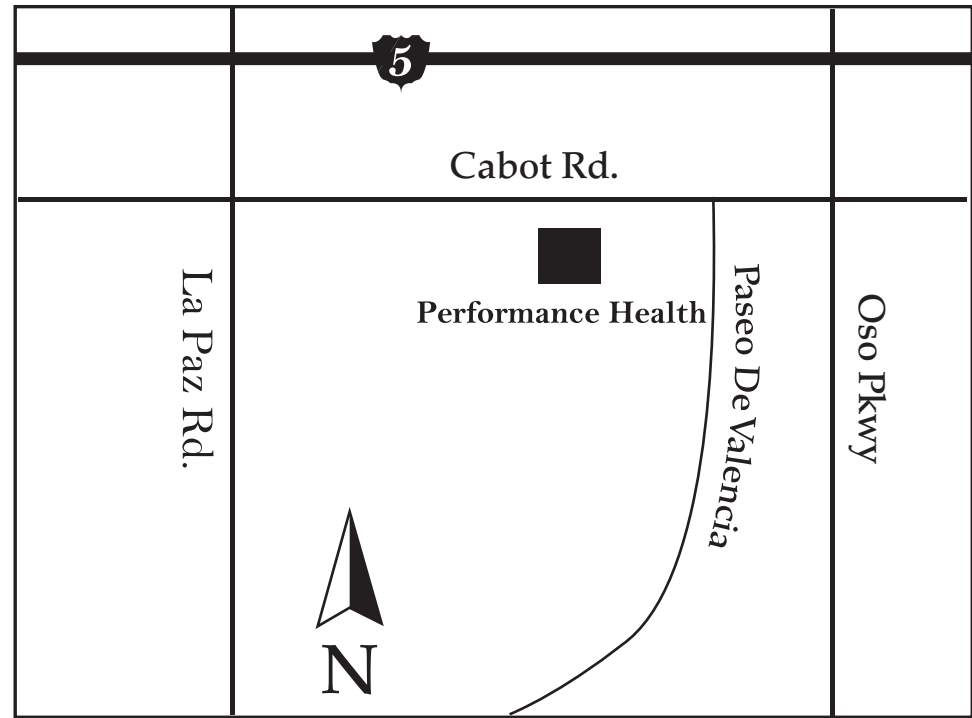
If yes, which Agency? _____

To authorize for medical treatment, form must be completed and signed. By authorizing medical treatment, the company assumes responsibility for any costs for medical services and other procedures.

Hours: Weekend 8:00 a.m. - 7:00 p.m.

Horas: Lunes a Viernes 8:00 a.m. - 7:00 p.m.

BETWEEN LA PAZ RD. AND OSO PKWY



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