WORKERS COMPENSATION AUTHORIZATION

Employee Name _____ **DOB** _____

SSN _____ **Claim # (if known)** _____

Date of Initial Injury _____

Please briefly describe injury _____

Has employee been treated elsewhere for this injury? _____

If yes, please indicate facility name and telephone # of initial treatment _____

_____

Employer Name _____

Address _____

City _____ **State** _____ **Zip** _____

Risk Manager _____

Telephone # _____ **Fax #** _____

Workers Compensation Insurance Company _____

Medical Billing Address _____

_____

Telephone # _____ **Fax #** _____

Additional Information _____

Information collected by _____**Date:**_____