RIVERSIDE URGENT CARE

MEDICAL AUTHORIZATION FORM

DATE: _____

Send the form with your employee or **fax** it to: **(985) 632-1824**

EMPLOYEE NAME: _____ **JOB/PO#**_____

COMPANY NAME: _____ **PHONE#**_____

COMPANY ADDRESS: _____ **FAX#**_____

CITY_____**STATE**_____ **ZIP CODE**_____

☐ **WORK COMP INJURY**

☐ Bill Company

☐ Bill workers comp. **insurance carrier**: It is the responsibility of the company to call in a First Report of Injury (Form 1007) to your workers compensation insurance carrier. Please provide carrier info and claim number below.

Workers Comp. Insurance Carrier

Company: _____

Phone: _____

Address: _____

Adjustor: _____

City: _____

State: _____Zip: _____

Please provide the claim number issued for this Workers Compensation Claim.
Your assistance in providing the claim number for this injury will expedite the management of this injury and the processing of claims. Claim#_____

☐ **URINE DRUG SCREEN**

☐ DOT (CDL)
☐ Non-DOT
☐ DOT Collection
☐ Non-DOT Collection
☐ Quick Screen

☐ **ALCOHOL TESTING**

☐ DOT
☐ Non-DOT
☐ Breath
☐ Saliva

☐ **REASON FOR TEST**

☐ Post Accident
☐ Pre-employment
☐ Random

☐ **PHYSICAL EXAMS**

☐ Non-DOT

AUTHORIZED BY:_____ ***TITLE*:**_____

(PRINT NAME) (REQUIRED)