Worker's Compensation Treatment Authorization

PATIENT INFORMATION

Patient Name:

DOB:

Email:

SSN:

Phone:

EMPLOYER INFORMATION

Employer Name:

Employer Address:

Primary Contact:

Phone: Email: Fax:

Alternative Contact (optional):

Phone: Email: Fax:

INJURY INFORMATION

Date of Injury:

Date Last Worked:

Injured Body Part & Description (optional):

CLAIMS ADMINISTRATION

Insurance Carrier / Claims Administrator:

Phone:

Claim # Assigned to Injury:

Employer/Insurer MPN Name (optional):

Electronic Billing Address **or** **Paper Billing Address**

Payer ID:

Clearinghouse:

Mailing Address:

Form must be completed in its entirety by an authorized representative of the employer. Exer Urgent Care to provide treatment to our employee. By doing so, we acknowledge that if the claim is denied by our insurance carrier, we will be responsible for payment for all services rendered & any medically-necessary items dispensed. Completed form must be presented to Exer during initial visit. For any questions, please reach out to billing@exerurgentcare.com

Authorized By:

Title:

Signature:

Date: