exer URGENT CARE™

Workers' Compensation Treatment Authorization

PATIENT INFORMATION

Patient Name: DOB:

Email: SSN:

Phone: Occupation/Job Title:

EMPLOYER INFORMATION

☐ I am a 1099 Employee (Self-Employed or Independent Contractor)

Employer Name: Type of Business:

Employer Address:

Primary Contact:

Phone: Email: Fax:

Alternative Contact (optional):

Phone: Email: Fax:

INJURY INFORMATION

Date & Time of Injury or Onset of Illness:

Date & Time of First Exam or Treatment:

Date Last Worked:

Address Where Injury Occurred:

Injured Body Part & Description (optional):

Have you or your office previously rendered treatment? ☐ Yes ☐ No

Describe how the accident or exposure happened. Be specific about any objects, machinery or chemicals involved:

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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: Mailing Address:

Clearinghouse:

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: