Workers' Compensation Treatment Authorization

PATIENT INFORMATION

First Name: Last Name:

DOB: ❗ **Please bring a valid ID to confirm your identity.**

EMPLOYER INFORMATION

Employer Name:

Employer Address:

Primary Contact:

Phone: Email:

CLAIMS ADMINISTRATION

Insurance Carrier / Claims Administrator:

Claims Billing Address:

Date of Injury:

Phone: Claim # Assigned to Injury:

This form must be completed in its entirety by an authorized representative of the employer. By signing this form, you agree to allow Exer Urgent Care to provide treatment to your employee. If the claim is denied by your insurance carrier, you will be responsible for payment for all services rendered and for any medically necessary items dispensed. This completed form must be presented to Exer Urgent Care staff during the employee's initial visit. For any questions, please reach out to **billing@exerurgentcare.com**.

Authorized By: Title:

Phone: Email:

Signature: Date: