EMPLOYER'S AUTHORIZATION FOR MEDICAL CARE

Instructions:

1. Employer to complete form with designated physician or clinic information and provide employee original signed form with copy retained.
2. Employee to present signed form to the physician or clinic designated by the employer upon initial evaluation.

Date of Injury: Click or tap here to enter text.
Employee Name: Click or tap here to enter text.
SSN: Click or tap here to enter text.
Medical Provider: Click or tap here to enter text.
Address City: Click or tap here to enter text.
Telephone: Click or tap here to enter text.

NOTICE TO EMPLOYEE:

Your employer has directed you to the above indicated medical provider for treatment of your reported industrial injury or illness. This provider is a member of your employer's medical provider network and you are required to receive all treatment related to your reported injury or illness within this network. Should you require additional evaluation, consultation or diagnostic testing from another provider, you will be referred to the appropriate specialist within the medical provider network. Any treatment received outside this medical provider network will be considered self-procured and at your own expense.

NOTICIA A EMPLEADO:

Su empleador se ha mandado al doctor indicado ambas para el tratamiento medico de su herida o enfermedal industrial, que se ha reportado. Este doctor es un miembro del "Medical Provider Network" de su empleador y se tiene que recibir todo el tratamiento medico para su herida o enfermedad adentro de este "Network". Si se necesita otra evaluación o cónsul con una especialista o pruebas diagnosticas de otro doctor, se refería a una especialista apropiada adentro del "Network". Si recibe tratamiento afuera del "Network", eso se considera tratamiento sin autorización y no lo pagaremos. Los gastos será la responsabilidad de Ud.

Employer: Click or tap here to enter text.
Telephone: Click or tap here to enter text.
Address: Click or tap here to enter text.
City: Click or tap here to enter text.
ZIP: Click or tap here to enter text.

Authorized Representative: Click or tap here to enter text.

Signature: _____

NOTICE TO MEDICAL PROVIDER:

Please immediately provide a complete doctor's first report of occupational injury or illness (Form 5021), and provide with a copy of this authorization to:

Carrier: Click or tap here to enter text. Policy Number: Click or tap here to enter text.
Address: Click or tap here to enter text. City: Click or tap here to enter text. Zip: Click or tap here to enter text.
Phone: Click or tap here to enter text. Fax: Click or tap here to enter text.