

Work CompTreatment Authorization Form

For Employer Paid Service, go to next page Employee must present authorization form and government issued Photo ID at time of service.

Patient Info						
Name:			Job Title:			
SS#:			DOB:			
Employer Info						
Name: BASTROP COUNTY		E	E-mail: chelse.peterson@co.bastrop.tx.			
Phone: 512-581-7108		F	Fax:			
Address: 804 PECAN ST		City: E	BASTROP	State: TX	Zip: 78602	
Work-Related Injury						
Claim Number: Date of Injury:		y:	Body Part(s) Authorized to Evaluate/Treat:			
Insurance Carrier Name: Sedgwick			Assigned Adjuster Name:			
Insurance Carrier Phone Number: 1-800-752-6301			Direct Phone Number:			
Fax Number:	Email Address:					
Is a post-accident drug screen and/or breath alcohol test required? (Check all that apply):						
No Post-Accident Testing Required DOT Breath Alcohol Test Non DOT Breath Alcohol Test						
Drug Screen: Standard: 5-Panel 10-Panel Rapid: 5-Panel 10-Panel DOT Drug Screen Other Panel						
Reason for Drug & Alcohol Test: Post-Accident Authorized By: Employer Insurance Carrier						
39804 -1918						
eScreen Acct #:						
EMPLOYER AUTHORIZATION: I authorize CareNow® Urgent Care to provide work related accident services and understand that my company (listed above) will be financially responsible for all services rendered to the patient (listed above).						
Chelse Peterson Chelse Peterson						
Employer Representative (Print Name) Employer Representative Signature Date						
Please contact our occupational medicine department to add or change services at CareNowOccMed@HCAhealthcare.com						
Scan here for clinic hours and to find a location, or go to CareNow.com						
CLINIC USE ONLY: VERBAL AUTHORIZATION RECEIVED BY THE ABOVE LISTED EMPLOYER REPRESENTATIVE						
CareNow Employee (Print Name)	CareNow Emp	loyee Ini	tials CareNow Loca	tion	Date	