Verification of workers' compensation and authorization for treatment

Patient information

Patient's name _____ Date _____

Patient's Social Security # _____ Date of injury _____

Patient's home address _____

Patient's DOB _____

Patient's phone _____

Employer information

Does employer participate in CWMP? _____

If yes, name and phone of CWMP _____ Phone _____

Employer name _____

Employer address _____

Employer's phone _____ Fax _____

Workers' Compensation insurance information

Insurance carrier _____

Mail claims to _____

_____

Insurer's Phone _____ Fax _____

Description of accident (Include body parts injured) _____

_____

_____

_____

Treatment authorization

To be completed by person authorizing treatment. Employer authorizes INTEGRIS to provide reasonable and necessary treatment for conditions related to the work-related injury/illness and employer authorizes INTEGRIS to provide the following specific procedures _____

_____

_____

_____

_____

Signature _____ Title _____

Printed name _____

INTEGRIS
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