Date _____

Work Comp Authorization for Medical Treatment

Employer Information

Employer: _____

Treatment Authorized by: _____

Title: _____

Telephone Number: _____

Injured Employee Information

Employee: _____ Social Security Number: _____

Job Title: _____

Department: _____ Location (s): _____

Date of Injury: _____ Body Part Injured: _____

Work Comp Insurance Carrier: Missouri Employers Mutual Insurance: 1.800.442.0593

Treatment Authorization

❑ Initial Evaluation and Treatment

- With Drug Screening
- Without Drug Screening
- With Breath Alcohol
- With Blood Alcohol

Note to employers: *You must have a Drug and Alcohol Policy in place that complies with Missouri law prior to selecting drug and alcohol screening.*

❑ Return-to-Work Exam

❑ Per Telephone Instructions

❑ Other _____

Remarks: _____

_____

Place this completed form in the Injured Employee Kit.
The form should be given to the treating physician.

DIMENSIONS
MEM's Comprehensive Health Solutions