BEE WELL URGENT CARE

PATIENT MUST PRESENT PHOTO ID AND AUTHORIZATION FORM AT THE TIME OF SERVICE

TREATMENT AUTHORIZATION FORM

EMPLOYER INFORMATION

Employer:		Work Comp Payer:	
Employer contact person:		Work Comp claim number:	
Employer contact phone:		Work Comp Payer address:	
Employer contact email:		Work Comp Payer email:	
Date of Incident:		Work Comp Payer fax:	

PATIENT INFORMATION

First Name:		Last Name:		Middle Initial:	
Date of Birth:		Social Security Number:			

REQUESTED SERVICES

DRUG SCREENS: ☐ URINE – 12 PANEL, IN-HOUSE ☐ IN-HOUSE SALIVA ☐ BAT ☐ HAIR ☐ URINE-SEND OUT

Reason: ☐ pre-employment ☐ post-incident ☐ cause/suspicion ☐ random ☐ DOT(send out only)

PHYSICAL: ☐ pre-employment ☐ DOT ☐ post-incident eval

☐ Respiratory fit eval ☐ Fit for Duty other:_____

WORK COMP DETAILS/HISTORY:

AUTHORIZED SIGNATURE:		DATE:	