Texas MedClinic®

Urgent Care | Occupational Medicine

www.texasmedclinic.com

Work-Related Injury Treatment Authorization

(This form is to be used as authorization to evaluate and treat an injured worker. If you only require drug testing services, please use Occupational Treatment Authorization.)

Employee Name: _____

Job Title: _____ **Social Security #:** _____ **DOB:** _____

Date of Injury: _____ **Claim # (if applicable):** _____

Company Name: _____ **Employer ID #** _____

Address: _____ **Dept / Location:** _____

Phone: _____ **Email:** _____

Person Authorizing (Please Print): _____ **Title:** _____

☐ **New Company Account with Texas MedClnic** ☐ **Existing Company Account with Texas MedClinic**

MEDICAL EVALUATION

☐ Physician Evaluation Only

☐ Physician Evaluation & Post Accident Testing

POST ACCIDENT DRUG & ALCOHOL TESTING

NON-DOT DRUG TESTING

☐ 5 Panel
☐ 10 Panel
☐ Rapid 5 Panel *
☐ Rapid 10 Panel *
☐ Hair Drug Test

**Rapid Drug Testing is Non-DOT Only using Texas MedClinic lab. Same day negative results before 2 pm, Mon-Fri. Specimens requiring further testing can take 2-7 business days depending on results and date/time of collection.*

DOT DRUG TESTING

☐ DOT Drug Test

DOT Testing Agency		DOT Testing Authority
☐ FMCSA	☐ FTA	☐ DOT
☐ FAA	☐ PHMSA	☐ HHS
☐ FRA	☐ USCG	☐ NRC

BREATH ALCOHOL TESTING

☐ Non-DOT
☐ DOT

Chain of Custody Form

☐ Electronic (Form Fox)
☐ Employee will hand carry
☐ Forms on file at clinic

Consortium/Third Party Administrator

☐ DISA ☐ Onsite Services
☐ CMI ☐ FleetScreen
☐ HireRight ☐ Other: _____

BILLING INFORMATION

To treat your work-related injury, Texas MedClinic MUST obtain the billing information for either your employer or your employer's Workers Compensation insurance. State laws set forth by the Division of Workers Compensation prohibit medical providers from billing or accepting payment from the patient for the treatment of work-related injuries if the company has Workers Compensation Insurance. If we CANNOT determine if your employer has insurance for work-related injuries OR proper billing information for your employer, our providers will ensure that you are medically stable and then you MAY be referred to the emergency room for further evaluation and treatment.

Name of Workers Comp Insurance (if applicable):

Billing Address:

Phone: **Fax:**

Email:

If you are a subscriber, are you in a Network? ☐ Yes ☐ No

Please indicate name of Network: _____

Workers Comp Billing Contact:

Phone:

Email:

NOTES:

Office Use Only: ☐ TA completed by Employer ☐ TA completed by Clinic Staff Staff Name: _____ Date: _____ Time: _____