

# 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: _____	
<input type="checkbox"/> New Company Account with Texas MedClinic <input type="checkbox"/> 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

### DOT DRUG TESTING

- ☐ DOT Drug Test

DOT Testing Agency	DOT Testing Authority
<input type="checkbox"/> FMCSA	<input type="checkbox"/> FTA
<input type="checkbox"/> DOT	
<input type="checkbox"/> FAA	<input type="checkbox"/> PHMSA
<input type="checkbox"/> HHS	
<input type="checkbox"/> FRA	<input type="checkbox"/> USCG
<input type="checkbox"/> 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: \_\_\_\_\_