



WORKER'S COMPENSATION AUTHORIZATION

I, _____, have been injured in an accident at my place of employment. I accept responsibility for any portion on my bill that may be rejected by my employer for any reason.

The information I have given concerning the name, address and telephone number of my employer is, to the best of my knowledge, true and correct.

I authorize **redicare** to contact my employer to verify the status of my employment and the validity of the Workmen's Compensation claim.

Urinary Drug Screen ___ Yes ___ No

PATIENT

WITNESS

DATE

PATIENT

WITNESS

COMMENTS

PRIMARY COVERAGE

EMPLOYER _____

PHONE NO. _____

COMPANY REP. _____

TIME _____

MAILING ADDRESS

ADDRESS _____

CITY _____

STATE _____ ZIP _____

INSTRUCTIONS:

AT THE TIME OF REGISTRATION, OBTAIN THE NAME AND PHONE NUMBER, IF POSSIBLE, OF THE EMPLOYER OF THE PATIENT. CONTACT THE EMPLOYER AS SOON AS POSSIBLE AFTER THE REGISTRATION AND BEFORE TREATMENT HAS BEEN RENDERED, AND INFORM THEM THAT THE PATIENT IS SEEKING TREATMENT FOR AN INJURY ALLEGEDLY SUSTAINED ON THE JOB. OBTAIN FROM THE EMPLOYER AN ADDRESS IN WHICH THE CLAIM SHOULD BE MAILED (AT THEIR PLACE OF BUSINESS). MAKE THE PATIENT AWARE THAT THEY ARE RESPONSIBLE FOR THE FULL BALANCE OF THE BILL. IF A PATIENT REFUSES A DRUG SCREEN OR IF THE EMPLOYER REFUSES TO GIVE AUTHORIZATION, MAKE THE ACCOUNT SELF PAY.

Has the patient been treated previously for this occurrence ___ Yes ___ No