CareNow Urgent Care

# Work CompTreatment Authorization Form

**For Employer Paid Service, go to next page**
Employee must present authorization form and government issued Photo ID at time of service.

Account Code: 16913

## Patient Info

| | |
|---|---|
| Name: | Job Title: |
| SS#: | DOB: |

## Employer Info

| | | | |
|---|---|---|---|
| Name: BASTROP COUNTY | | E-mail: chelse.peterson@co.bastrop.tx. | |
| Phone: 512-581-7108 | | Fax: | |
| Address: 804 PECAN ST | City: BASTROP | State: TX | Zip: 78602 |

## Work-Related Injury

| Claim Number: | Date of Injury: | Body Part(s) Authorized to Evaluate/Treat: |
|---|---|---|
| | | |

| | |
|---|---|
| Insurance Carrier Name: Sedgwick | Assigned Adjuster Name: |
| Insurance Carrier Phone Number: 1-800-752-6301 | Direct Phone Number: |
| Fax Number: | Email Address: |

Is a **post-accident** drug screen and/or breath alcohol test required? (Check all that apply):

☒ **No Post-Accident Testing Required** ☐ DOT Breath Alcohol Test ☐ Non DOT Breath Alcohol Test

**Drug Screen:** ☐ Standard: 5-Panel 10-Panel (Circle one) ☐ Rapid: 5-Panel 10-Panel (Circle one) ☐ DOT Drug Screen ☐ Other Panel

**Reason for Drug & Alcohol Test:** ☐ Post-Accident **Authorized By:** ☐ Employer ☐ Insurance Carrier

**eScreen Acct #:** 39804 -1918

**EMPLOYER AUTHORIZATION:**
I authorize CareNow® Urgent Care to provide work related accident services and understand that my company (listed above) will be financially responsible for all services rendered to the patient (listed above).

| Employer Representative (Print Name) | Employer Representative Signature | Date |
|---|---|---|
| Ashley Piper | Ashley Piper | |

Please contact our occupational medicine department to add or change services at **CareNowOccMed@HCAhealthcare.com**

Scan here for clinic hours and to find a location, or go to **CareNow.com**

☐ **CLINIC USE ONLY:** VERBAL AUTHORIZATION RECEIVED BY THE ABOVE LISTED EMPLOYER REPRESENTATIVE

| CareNow Employee (Print Name) | CareNow Employee Initials | CareNow Location | Date |
|---|---|---|---|
| | | | |