

 ***Authorization for Initial Services or Treatment***

“This document authorizes initial evaluation and treatment only, and

payment for these services will be rendered without prejudice”

|  |  |  |  |
| --- | --- | --- | --- |
| *Medical Facility:* |  | *Employer Name:* |  |
| *Contact:* |  | *Contact:* |  |
| *Phone* |  | *Address:* |  |
| *Fax:* |  | *Phone:* |  |

|  |  |
| --- | --- |
| *Claimant Name:* |  |
| *Date of Birth:* |  |
| *Claim # or SSN#* |  |
| *Date of Injury:* |  |
| *Body part(s)* |  |

***Employee:*** *Please take this form with you to an authorized treating physician. By signing this form, I certify that the treating physician may release medical information related to this evaluation to pertinent parties.*

*Date: Employee Signature:*

***Authorized Medical Facility:***

*Please accept this form as a (1) one time authorization for the above named employee to treat at your medical facility.*

***Injury/Illness***

*[x]  Treatment for an alleged work related injury or illness [x]  Drug Screen with initial injury visit*

***Drug / Alcohol Test***

*[x]  5 panel [ ]  7 panel [ ]  10 panel*  ***Other:***

***Reason***

*[x]  Post-accident*

*Should you have any further questions regarding this Authorization for services, please call USIS at 800-444-9098. Please send work status, medical notes or referrals to* *emailattach@usis-tpa.com* *or fax to (407) 352-5788.*

*For billing and general questions:*

*Billing address:*

***USIS – Claims Department***

***P.O. Box 616648***

***Orlando, FL 32861-6648***