SELF INSURERS FUND, INC.
www.frsasif.com • 1-844-677-3772 • FAX (407) 671-2520

Authorization for Initial Services or Treatment

1/30/2015

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:
Dear Facility,

I am the employer for the above referenced employee/patient. Please accept this letter as my authorization for initial treatment of the above mentioned employee for his/her work related injury.

Date: _____ Employer Signature: _____

Injury/Illness
☒ Treatment for an alleged work related injury or illness ☒ Drug Screen with initial injury visit
Drug / Alcohol Test
☒ 5 panel ☐ 7 panel ☐ 10 panel **Other:**_____
Reason
☒ Post-accident

Should you have any further questions regarding this authorization for services, please call FRSA-SIF (844) 677-3772.
Please send work status, medical notes or referrals to mail@frsasif.com or fax to (407) 671-2520.
For billing and general questions:

Billing address:
FRSA Self Insurers Fund Claims Dept.
PO BOX 4910
WINTER PARK FL 32793