



RANCHO PASEO

MEDICAL GROUP

Total Family Care

## Medical Treatment Authorization

Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Confidential Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Carrier: \_\_\_\_\_

Adjuster: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Billing Address: \_\_\_\_\_

### Authorization is given for the following treatment:

Work Injury on \_\_\_\_\_ (date of injury)

YES / NO First Report Included: \_\_\_\_\_

YES/NO Claim Number: \_\_\_\_\_

YES/NO Is Modified Work Available? \_\_\_\_\_

Pre-Employment Physical  
Special Instructions (i.e. DMV physical): \_\_\_\_\_

Drug Screen (5 Panel urine collection will be performed if other not specified)  
Special Instructions: \_\_\_\_\_

X-RAYS (specify): \_\_\_\_\_

Other: \_\_\_\_\_