# Authorization of Initial Medical Treatment

Please be advised that the individual presenting you with this form is an employee of the below named organization and is seeking treatment for an injury/illness that they have reported to be work-related. This document authorizes you to provide an initial examination and treatment of the employee. Continuing or follow-up treatment must be coordinated with, and authorized by, our Third Party Administrator (TPA). They will determine whether continuing treatment will be covered by Workers' Compensation. Thank you in advance for your service and cooperation.

This is to authorize medical treatment for _____,

**Employee Name**

an employee of _____ for a work-related injury, which is,

**Employer**

reported to be: _____

**Nature of Injury/Illness**

Address where injury/illness occurred: _____

**If this treatment qualifies as a First Aid treatment, please send bill to:**

Contact: _____

Employer: _____

**Legal Entity Name**

Address: _____

Phone: _____ Fax: _____

We strongly suggest that providers contact the employer referenced on the front of this form to verify authorization for treatment prior to rendering service. This will help avoid fraudulent use of authorization forms.

Authorized Employer Signature

_____ _____ _____

**Print Name and Title** **Date** **Signature**

Otherwise, bills can be sent to American Claims Management:

American Claims Management
P.O. Box 85251
San Diego, CA 92186-5251

Phone: 1-866-671-5042
Fax: 1-619-744-5030

**Employer has an extensive Early Return-to-Work/Modified-Duty Program**

# Autorización De Iniciación De Tratamiento Médico

Esta es una autorización para tratamiento médico para _____,
**Nombre del trabajador**

Empleado por _____ por un accidente y/o lesión laboral,
**Empleador**

Que se reportó como: _____
**Naturaleza del accidente y/o lesión**

Dirección donde ocurrió el accidente y/o lesión: _____

_____

_____

**Si éste tratamiento médico puede ser calificado como primeros auxilios, por favor envíe su factura a:**

Persona a Contactar: _____

Nombre Legal del Empleador: _____

Dirección: _____

Teléfono: _____ Fax: _____

**Firma autorizada del Empleador:**

_____ _____ _____
**Firma** **Fecha** **Nombre completo y Cargo Administrativo**

Caso contrario, las facturas pueden ser enviadas a la oficina de American Claims Management más cercana a su localidad médica:

American Claims Management
P.O. Box 85251
San Diego, CA 92186-5251

Phone: 1-866-671-5042
Fax: 1-619-744-5030

**El Empleador participa en un Programa extenso para reintegro rápido del trabajador tal como, trabajo modificado o trabajo alternativo.**