Medical Authorization For Treatment

Authorization Not Valid Unless Signed By Employer

Administrator's Signature _____ Date _____

Facility _____

_____

_____

To: Doctor or Medical Facility _____

Your are authorized to give first aid, medical or surgical treatment as necessary to our employee _____ for the alleged work related injury subject to the provisions of the Worker's Compensation Act. Although we will forward any expenses incurred to our Worker's Compensation carrier, we cannot guarantee this claim will be compensable.

NOTE TO EMPLOYEE: I understand that I will be responsible for the cost of all services rendered for treatment, should Discovery Insurance Company determine my injury/injuries to be non-compensable.

Employee Signature: _____ Date _____

To Be Completed By Physician

Name _____ Date of Service _____

Time Arrived _____ a.m./p.m. Time Left _____ a.m./p.m.

Diagnosis _____

Treatment _____

Medications Prescribed _____

Work Status: _____ Employee Released To Regular Duty At This Time
_____ Employee Released To Modified Duty With The Following Restrictions: _____
_____ Employee Excused From **ALL** Duties Until _____

Projected Date of Return To Regular Duty: _____ Modified Duty: _____

Next Appointment Date: _____ Time: _____

Physician's Signature: _____ Date: _____

Mail the original of this form to Discovery Insurance Company, P.O. Box 200, Kinston, NC 28502. Questions, please dial (252) 523-1200 extension 24104.

Print Reset Form