

DATE \_\_\_\_\_



## WORK COMP AUTHORIZATION FOR MEDICAL TREATMENT

### EMPLOYER INFORMATION

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

Treatment Authorized by: \_\_\_\_\_

Title: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

### INJURED EMPLOYEE INFORMATION

Employee: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Job Title: \_\_\_\_\_

Department: \_\_\_\_\_ Location (s): \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Body Part Injured: \_\_\_\_\_

*Work Comp Insurance Carrier: Missouri Employers Mutual Insurance: 1.800.442.0593*

### TREATMENT AUTHORIZATION

*Please check all that apply:*

Initial Evaluation and Treatment

Alcohol Screening

Drug Screening

*Note to employers: You must have a Drug and Alcohol Policy in place that complies with Missouri law prior to selecting drug and alcohol screening.*

Return-to-Work Exam

Per Telephone Instructions

Other \_\_\_\_\_

**REMARKS:** \_\_\_\_\_

Submit a copy of this completed form to Missouri Employers Mutual by fax at 1.800.442.0597 or email it to [claims@mem-ins.com](mailto:claims@mem-ins.com).

*Place this completed form in the Injured Employee Kit to go to the treating physician.*