TREATMENT AUTHORIZATION

AUT

U.S. HealthWorks MEDICAL GROUP
A Dignity Health Member

We are authorizing the below listed U.S. HealthWorks(s) to provide treatment to our employees. By doing so, we acknowledge that if the claim is denied by our insurance carrier, we will notify USHW of the denial and will be responsible for payment for all services rendered and any medically-necessary items dispensed.

1. BRANDON
934 Oakfield Dr
Brandon, FL 33511
Ph: (813) 242-5641
Fx: (813) 689-5486
Mon-Fri: 8 am - 5 pm

2. PLANT CITY
2303 N Airport Rd
Plant City, FL 33563
Ph: (813) 752-1195
Fx: (813) 754-4478
Mon-Fri: 8 am - 5 pm

3. TAMPA-AIRPORT
5406 Hoover Blvd, Ste 21
Tampa, FL 33634
Ph: (813) 248-8149
Fx: (813) 884-7085
Mon-Fri: 8 am - 5 pm

4. TAMPA-DOWNTOWN
1750 N 50th St
Tampa, FL 33619
Ph: (813) 247-4489
Fx: (813) 247-4480
Mon-Fri: 7:30 am - 5 pm

5. TAMPA-EAST
3012 US Hwy 301 N, Ste 100
Tampa, FL 33619
Ph: (813) 490-0099
Fx: (813) 490-0204
Mon-Fri: 8 am - 5 pm

6. TAMPA-PLAZA TERRACE
4728 N Habana Ave, Ste 102
Tampa, FL 33614
Ph: (813) 870-4485
Fx: (813) 554-8116
Mon-Fri: 8 am - 5 pm

7. TEMPLE TERRACE
10320 N 56th St, Ste 110
Temple Terrace, FL 33617
Ph: (813) 980-3151
Fx: (813) 980-3731
Mon-Fri: 8 am - 5 pm

Company Name _____ Employer # _____

Primary Contact Name _____

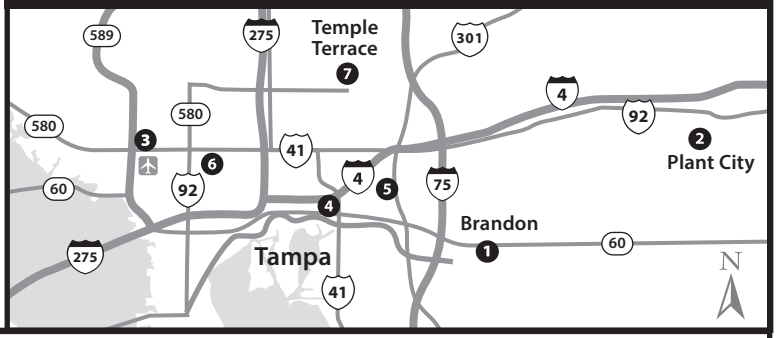
Address Line 1 _____

City _____ State _____ Zip _____

Ph _____ Fx _____

Ph (after hrs/cell) _____ Email _____

HILLSBOROUGH COUNTY



EMPLOYEE DETAILS

PATIENT NAME: _____ DATE: _____ TIME: _____ AM / PM

DEPARTMENT: _____ POSITION: _____

DOES EMPLOYEE WORK FOR A TEMP/LEASING COMPANY? ❑ YES ❑ NO NAME OF TEMP AGENCY: _____

AUTHORIZED BY: NAME (print): _____ PHONE: _____

TITLE: _____ AFTER HRS / CELL PHONE: _____

SIGNATURE: _____ ( ) VERBAL AUTHORIZATION

INSURANCE

INSURANCE COMPANY NAME: _____

CLAIMS ADDRESS: _____

PHONE: _____ EFFECTIVE DATE: _____

POLICY #: _____ EXPIRATION DATE: _____

SERVICES

O INJURY: DATE OF INJURY: _____ LAST WORKED: _____

INJURED BODY PART: _____ CLAIM #: _____

O RETURN-TO-WORK EVALUATION: _____

O PHYSICAL EXAM TYPE: _____ PROTOCOL #: _____

O DRUG/ALCOHOL TEST - specify type and reason/purpose below: PROTOCOL #: _____

TYPE:
❑ DOT DRUG TEST ❑ DOT BREATH ALCOHOL TEST
Agency (required): _____
❑ NON-DOT DRUG TEST ❑ NON-DOT BREATH ALCOHOL TEST
❑ INSTANT DRUG TEST

REASON/ PURPOSE:
❑ PRE-EMPLOYMENT ❑ RANDOM
❑ REASONABLE SUSPICION ❑ POST-ACCIDENT
❑ RETURN TO DUTY ❑ FOLLOW UP
❑ POST-INJURY

Perform test before: Date: _____ Time: _____ AM / PM

*** PICTURE ID REQUIRED FOR DRUG TEST**

Rev 12/21/2016