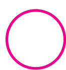
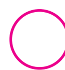
TREATMENT AUTHORIZATION



AUT


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. ORLANDO-NORTH
4780 N Orange Blossom Trail
Orlando, FL 32810
Ph: (407) 206-3326
Fx: (407) 206-3316
Mon-Fri: 7:30 am - 5 pm

2. ORLANDO-PRINCETON
2314 N Orange Blossom Trail
Orlando, FL 32804
Ph: (407) 428-9233
Fx: (407) 428-9667
Mon-Fri: 8 am - 5 pm

3. ORLANDO-SOUTH I
9500 Satellite Blvd, Ste 100
Orlando, FL 32837
Ph: (407) 859-5656
Fx: (407) 859-2124
Mon-Fri: 7 am - 5 pm

4. ORLANDO-SOUTH II
8010 Sunport Dr, Unit 116
Orlando, FL 32809
Ph: (407) 851-0883
Fx: (407) 857-4722
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 ______

ORANGE 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
Agency (required): ______
❑ DOT BREATH ALCOHOL TEST
❑ 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**

U.S. HealthWorks

Rev 07/29/2016