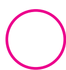
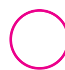
TREATMENT AUTHORIZATION



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. DUNEDIN
2323 Curlew Rd, Stes 2A & 2B
Dunedin, FL 34698
Ph: (727) 781-3480
Fx: (727) 781-3912
Mon-Fri: 8 am - 5 pm

2. LARGO
1400 East Bay Dr
Largo, FL 33771
Ph: (727) 586-0047
Fx: (727) 585-7867
Mon-Fri: 7:30 am - 5 pm

3. ST. PETERSBURG-Carillon
900 Carillon Pkwy, Ste 106
St. Petersburg, FL 33716
Ph: (727) 532-7661
Fx: (727) 561-9865
Mon-Fri: 8 am - 5 pm

4. ST. PETERSBURG-33rd St
3745 33rd St N, Ste A
St. Petersburg, FL 33713
Ph: (727) 231-0154
Fx: (727) 231-0158
Mon-Fri: 8 am - 5 pm

Company Name ______ Employer # ______

Primary Contact Name ______

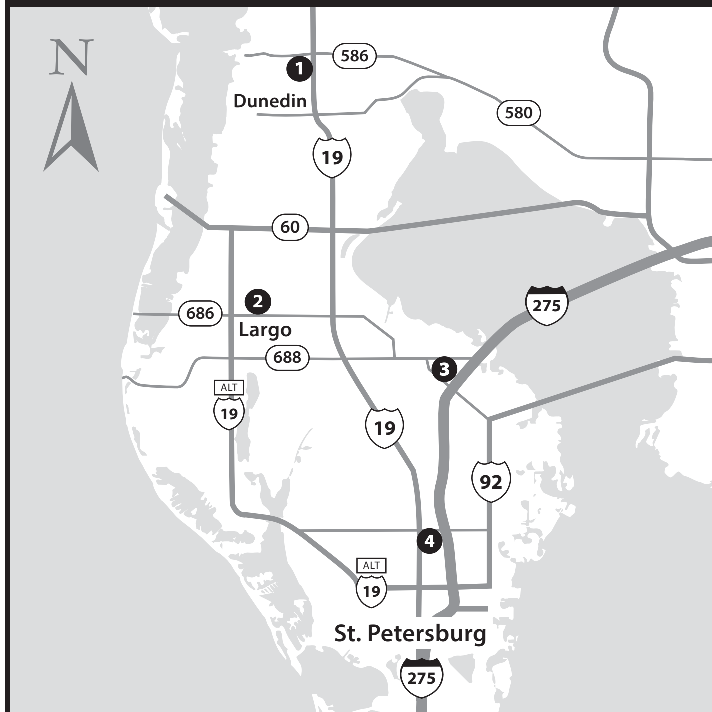
Address Line 1 ______

City ______ State ______ Zip ______

Ph ______ Fx ______

Ph (after hrs/cell) ______ Email ______

PINELLAS 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