WORKER'S COMPENSATION AUTHORIZATION FOR TREATMENT

LETTER OF AUTHORIZATION

(TO BE COMPLETED BY PATIENT'S EMPLOYER)

Patient Name: ____ Date: ____________________

Employer Information (REQUIRED INFORMATION)

Company Name: ____

Contact Person: ____

Address: ____

City/State/ Zip: ____

Phone Number: ____

Insurance Carrier (REQUIRED INFORMATION)

Name: ____

Address: ____

City/State/ Zip: ____

Phone Number: ____

__________________________________ Reported to our office for examination and treatment due to an injury he/she received on the job, and he/she states that you are his/her employer. This office needs verification that this injury did occur **on the job** and that his/her treatments **will be covered by Workers' Compensation Insurance**. Please sign and return this written authorization for treatment to our office.

Thank you,

Dr. Philip S. Seng, D.C.

______________________________ ______________________________

Date Authorized Signature

DR. PHILIP S. SENG

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www.drseng.com

WORKER'S COMPENSATION AUTHORIZATION FOR TREATMENT

LETTER OF AUTHORIZATION

(TO BE COMPLETED BY WORKER'S COMPENSATION INSURANCE CARRIER)

Insurance Carrier

Name: ______________________________

Address: ______________________________

City/State/ Zip: ______________________________

Phone Number: ______________________________

Fax Number: ______________________________

Claim Number: ______________________________

Company Name: ______________________________

______________________________ Reported to our office for examination and treatment due to an injury he/she received on the job, and he/she states that you are his/her employer. This office needs verification that this injury did occur on the job and that his/her treatments will be covered by Workers' Compensation Insurance. Please sign and return this written authorization for treatment to our office. Our initial visit will consist of an examination, x-rays and treatment. Upon completion of the initial visit, treatment notes and reports will be forwarded to your attention and well will await further authorization. *The signature below constitutes authorization for the initial visit only.*

Thank you,

Dr. Philip S. Seng, D.C.

______________________________ ______________________________
Date Authorized Signature