1300 Old Weisgarber Road
Knoxville, TN 37909
Phone: 865-584-2146
Fax: 865-558-8963

Treatment Authorization Form

Please retain a copy for your records. Original will remain on file at MedCare Specialists.
Please provide each employee with this form at time of service(s).

Employee Name: ____**DOB:**__________________
Employer (Company): ____
Position: ____
Employer (Company) Phone Number: (______)________________________ **ext.** ______________
Fax Number: (______)__________________________ **e-mail address:** _________________________

Work-Related Injury: YES ______ NO ______
Please provide any medical treatment necessary for the proper care of the above named employee.
Date injury occurred: ____
Type of injury: ____
Has the employee ever injured this area before? YES __________ NO _________
Do you wish to conduct Post-Accident Drug Screening? YES ________ NO ________
Do you wish to conduct Post-Accident Breath Alcohol Testing? YES _________ NO _______
Has a first report of injury been completed? YES ________ NO ________

PHYSICAL TO BE COMPLETED   CIRCLE SELECTED PHYSICAL

Please perform the following physical examination(s):

Pre-Employment	DOT Physical	NON-DOT Physical
Re-certification	Respirator Exam	Lumbar Examination

Other please specify____

DRUG TEST TO BE COMPLETED   CIRCLE SELECTED TEST

DOT   OR   NON-DOT

Reason for Test   **Pre-employment   Random   Post-Accident   Follow up**
Return to Duty   Reasonable Suspicion

CIRCLE TYPE OF SCREEN

DOT Drug Screen

OR ~ **NON- DOT** **5-panel** **Instant 5-Panel** **9-panel** **Instant 9-panel**
9-Panel plus synthetic (Non-DOT) **Breath Alcohol Test** **Hair Test**

Other Services

TB Shot: _______ Audiometric: _______ Pulmonary Function: _______ Hepatitis B: ________

Flu Shot: _______ Chest X-Ray: _______ Other (please specify): ____________________________

How are the services rendered today to be billed? One of the following MUST be marked.
Employer? __________________ Paid by Employee at time of services?______________
Workers Compensation Insurance Carrier? ________ **(If workers comp. please complete information below.)**

Workers Compensation Insurance Carrier: ____
Address: ____
City: ______________________________ State:______________________ ZIP: ___________________
Phone: (______)_____________________ Claim #: ____

The above treatment is authorized by: ____
(Please Print)

On behalf of (Company): ____

Signature of Authorizing Agent **Date** **Time**