MEDNOW
Urgent + Primary Care

Employer Authorization for Worker's Compensation Treatment
PHOTO ID IS REQUIRED FOR ALL SERVICES

Patient Name:_____ DOB:_____SSN:_____

Address: _____ Phone:_____

Date of Injury: _____ Claim Number: _____

Reason for Test:

- ✓ Post- Accident

Substance Abuse Testing:

☐ Drug Screen (☐ DOT-Federal ☐NON-DOT ☐10 Panel Instant)
☐ Breath Alcohol (☐ DOT-Federal ☐NON-DOT)

Remittance of Restrictions Form/Results:

- ☐ Fax: _____
- ☐ Email: _____

Company Name:_____ **Authorized By:**_____

Phone: _____ **Date:**_____

Billing Information: ☐ Bill Employer ☐ Bill Insurance

Company Address: _____

Insurance Company: _____

Insurance Address: _____

Insurance Phone: _____ Fax: _____

Substance Abuse Testing Billing:

****Please complete this section if the Drug Screen or Breath Alcohol performed is not covered by worker's comp insurance policy and should be billed to employer or third-party administrator.**

☐ Bill Employer ☐ Bill TPA- _____

Billing Address: _____

Phone: _____ Fax:_____

Contact:_____

How would you like to receive results? Email-_____ **Fax-** _____