NOTICE TO MEDICAL PROVIDER – AUTHORIZATION FOR TREATMENT

THIS IS A WORK-RELATED INJURY

This form must accompany an injured worker to the medical provider's office or emergency room.

WORKERS' COMPENSATION INFORMATION

Employee Name: _____ Today's Date: _____

Date of Accident/Injury: _____ Time of Accident/Injury: _____ am pm

Injury Description: _____

EMPLOYER INFORMATION

Employer Name: _____

Employer Address: _____

Employer Contact Name: _____

Contact Phone No.: _____ Fax No.: _____

Contact Email: _____

WORKERS' COMPENSATION BILLING INFORMATION

Coverage Type: **Workers' Compensation / Employers' Liability**

Policy No.: _____ Claim No.: _____

Insurance Carrier: **Alabama Retail Comp, P.O. Box 240549, Montgomery, AL 36124-0549**

Carrier Phone No.: **(800) 239-5423** Carrier Fax No.: **(334) 263-1976**

Carrier Email: **claims@alabamaretail.org**

Standard office visits and x-rays approved. Prior approval is required for all other treatment and/or referrals.

DRUG SCREEN INFORMATION

Is a drug screen required? ☐ **YES** ☐ **NO** ☐ **NON-DOT** ☐ **DOT**

When? **Post-Accident – within 32 hours of the accident**

Send Test Results to: **1. Alabama Retail Comp – Fax (334) 263-1976**

2. Employer

BREATH ALCOHOL TESTING

Is a breath alcohol test required? ☐ **YES** ☐ **NO**

When? **Post-Accident – within 8 hours of the accident**

Send Test Results to: **1. Alabama Retail Comp – Fax (334) 263-1976**

2. Employer

_____ _____

Approved by (Employer Representative Name & Job Title) Phone Number