PEACHTREE IMMEDIATE CARE

Treatment Authorization Form

Date:_____ Time:_____

Company Name:_____ Company Address:_____

Authorized by (signature):_____ Patient Name:_____

Authorizer's Email:_____ Patient SS #:_____

Authorizer's Phone #:_____ Date of Injury:_____ Body Part:_____

Reason for Visit

DRUG SCREENING: ☐ Post-Accident ☐ Random ☐ Pre-Employment ☐ Reasonable Suspicion ☐ Return to Work

INJURY CARE: ☐ Treat injury only – NO DRUG SCREEN ☐ Treat Injury – PERFORM DRUG SCREEN

Requested Services (Please ✖ all that apply)

DOT	Non-DOT	OTHER SERVICES
☐ Physical ☐ Drug Screen Collection ☐ Drug Screen Our Lab ☐ Pre-Placement ☐ Random ☐ Reasonable Suspicion ☐ Post Injury ☐ Annual ☐ Other	☐ Physical ☐ Drug Screen Drug Screen Our Account Send out _____ ☐ 5 Panel ☐ 10 Panel Instant Our Kit _____ ☐ 5 Panel ☐ 10 Panel Collection/Send out (COC Requisition Provided or on File) _____ ☐ Hair Follicle Test	☐ Audiogram ☐ Pulmonary Function Test (PFT) ☐ Respirator Clearance Physical ☐ Respirator Questionnaire ☐ TB Test ☐ T-dap Vaccination ☐ X-Ray ☐ EKG ☐ Other:_____

BILLING:

☐ Employee to SELF PAY Billing Contact Name: _____ Phone: _____

☐ Employer Paid Carrier Name: _____ Phone: _____

☐ Insurance Carrier/TPA Carrier Address: _____

_____

Claim #:_____

Rev 4/2017