



Workers' Compensation Authorization Form

ANYTHING IN BOLD WITH (*) MUST BE FILLED OUT

PATIENT INFORMATION - PLEASE PRINT CLEARLY!

***Name:** _____

***Social Security #** _____
(required)

Address: _____

***Date of Injury:** _____

City, State, Zip: _____

Patient Complaint: _____

Phone: _____

Patient Account # _____

***Date of Birth:** _____

Sex: **Male** **Female**

EMPLOYER INFORMATION - PLEASE PRINT CLEARLY!

***Employer:** _____

Carrier: _____

Address: _____

Address: _____

City, State, Zip: _____

City, State, Zip _____

***Phone:** _____

Phone: _____

Contact: _____

Contact: _____

Treatment already authorized? **Yes or No**

If so by whom? _____

Initial I agree to provide Advantage Urgent Care with
all necessary information to bill within 48 hours

Initial I understand that if my ICA/Workers Compensation
carrier does not cover my visit, I will be held responsible
for the balance.

Initial I understand that this visit may not be covered
by my personal Insurance carrier.

Patient Signature

Date: