TREATMENT AUTHORIZATION FORM

Form to be presented to physician's office for treatment.

EMPLOYEE INFORMATION

(Valid identification is needed for all drug screens and breath alcohol tests)

Name: _____ **Position:** _____ **Date:** _____

SCREENS REQUIRED UPON TREATMENT: ☐ **Breath Alcohol Test** ☐ **Instant Drug Test**

EMPLOYER INFORMATION AND AUTHORIZATION

AUTHORIZED TREATMENT PROVIDER: _____

SUPERVISOR NAME: _____ **OFFICE:** _____ **FAX:** _____

CONTACT PERSONNEL: _____ **OR** _____

Please call _____ at _____ after treatment

AUTHORIZATION: This form, completed and signed by an authorized representative of _____, serves as authorization to treat the above named employee and to bill for services rendered. Please submit a first report of this injury to the company as soon as possible.

Authorized Signature: _____ **Date:** _____

BILLING INFORMATION

Submit all billing to:

AlaCOMP /Business Insurance Group
PO Box 243007
Montgomery, Alabama 36124