Workers Compensation Authorization Form

Date :_____ Patient Name _____ Social Security # _____-____ _____

Employer:		
Phone:		Fax:
Employer Address:		
Primary Contact:		
E-mail:		

REQUIRED FOR ALL WORKERS' COMPENSATION VISITS – If no authorization is received from Employer/Supervisor, patient will need to provide insurance and place credit card on file.

Type of Injury:	
Where are the claims to be filed?	
☐Bill Employer or Paying Today ☐ (Self Pay Work Comp)	☐W/C Insurance Carrier W/C Carrier Name:_____
How do you want to receive the Return To Work report? Please enter email address or fax number below.	
☐Fax :_____	☐Secure Email : _____

Authorized Services ***NOTE Tests below will be billed to the employer and NOT to WC Carrier**		
☐6 Panel Rapid DS	☐10 Panel Rapid DS	☐No Drug Screen required
☐DOT DS (Company CCF)	☐DOT DS (Twin Rivers CCF)	
☐Non DOT DS (Company CCF)	☐Non DOT DS (Twin Rivers CCF)	
☐DOT BAT	☐Non DOT BAT	☐No BAT required

Employer: *This certifies that the above information is correct. I authorize the medical provider to provide medical treatment to the employee named above.*

X_____ _____ _____ _____

Employer Signature | Date | Printed Name | Title

Patient: *I understand that in the event this service(s) does not qualify for coverage under the provided workers compensation, I will be responsible for all charges and will provide Twin Rivers Health Care with my insurance information or, if non-insured, will pay for services rendered in full.*

X_____ _____ _____

Patient Signature (Required) | Date | Printed Name

Internal Office User Only

Admissions Staff Name:	Clinical Staff Name:	Location:

Twin Rivers HEALTHCARE

Workers Compensation Authorization Form

Credit Card Authorization Form

Type: ☐Visa ☐MasterCard ☐Discover ☐American Express

Name on Card: _____

Card Number: _____

Expiration Date: _____

3 Digit Security Code: _____

Card Billing Address: _____ City: _____ State: _____ Zip Code: _____

I, _____, authorize Twin Rivers Health Care to charge my credit card for the agreed upon services. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Card Holder Signature Date

Locations:

Grand Island

Twin Rivers Sports Medicine &Family Medicine
7220 N Webb Rd
Grand Island, NE 68803
Phone: 308-395-7700
Fax: 308-395-7713
Office Hours
Monday-Thursday 8am-5pm
Call ahead for Appointments 308-395-7700

Grand Island After Hours Location
Twin Rivers Urgent Care
750 Allen Dr Grand Island, NE 68803
Ph: 308-384-2500
Fax: 308-384-2565
Office Hours
Monday-Friday 8am-8pm
Saturday 9am-6pm
Sunday 12pm-5pm

Hastings

Twin Rivers Urgent Care
3203 Osborne Dr West Ste 101
Hastings, NE 68901
Phone: 402-834-1005
Fax: 402-303-1022
Office Hours
Monday -Friday 8am-8pm
Saturday 9am-6pm
Sunday 12pm-5pm

Visit Us Online@

www.trurgentcare.com