

MEDICAL TREATMENT AUTHORIZATION

Send copy to Healthcare Provider along with Physicians Report. Retain original for file.
Fax this completed form to **FAS - FAX (972) 930-9479** OR Email to **CLAIMS@FASTPA.COM**

EMPLOYER INFORMATION:

NAME _____
ADDRESS _____ City _____ State TX Zip _____
PHONE _____ FAX _____ Policy# _____

(Name of Employee)

(Social Security Number)

To: Approved Provider

The above referenced employee has reported sustaining an occupational injury/illness related to his or her employment. You are authorized to provide medically necessary treatment and/or prescription services for conditions related to the reported injury/illness.

Drug/Alcohol Screen Required Yes No

If this box is signed and dated, the employee is required to submit to a drug/alcohol screen which is only for the initial examination and emergency treatment of the injury noted below. Please conduct a drug/alcohol screen for your panel of controlled substances and alcohol, in addition to treating the occupational injury/illness. The results of the drug/alcohol screen must be reported only to the Employer.

(Authorized Supervisor or Manager)

Date

Type of Injury _____

The attached Physician's Report of Employee injury ("Report") must be completed by the treating physician. Please provide the employee with a copy of this Report and attach a copy to your billing document.

Your charges for medically necessary services will be paid directly by the Employer. To facilitate prompt payment, submit your billing document and a copy of the Report (physicians only) to:

FAS
P O BOX 2309
Addison, Texas 75001

Treatment and billing inquiries should be directed to *FAS, Inc.* at (866) 930-9493. For authorization to release medical records and other information relating to the above employee's occupational injury/illness, refer to Medical Records Release Authorization.

Supervisor/Manager Name - Printed

X _____
Supervisor/Manager Signature

Date