Workers Compensation Authorization Request

DATE REQUESTED: _____

EMPLOYER: _____

_____

EMPLOYEE: _____

DATE OF INJURY: _____

INSURANCE CARRIER: _____

CLAIM / CASE / POLICY NUMBER: _____

ADJUSTER: _____ PHONE: _____ EXT: _____

The Employee named above has consulted our clinic for treatment under Worker's Compensation Insurance for an On-the-Job Injury. The Employee was referred for acupuncture treatments by_____

_____

_____

_____

Enclosed please find:

☐ Referral Letter ☐ Statement of Medical Necessity ☐ Sate License Copy

Please review enclosed information and authorize our request. Your prompt response will be greatly Appreciated.

Were Acupuncture Treatments authorized? _____ Yes _____ No

How many Acupuncture treatments were authorized: _____

_____

(Signature of the person authorized treatments) (Date)

Please mail authorized request to the clinic address below, or fax to (949) 854-4743
If you have any questions or need any further information please do not hesitate to contact Billing Service at ( ) _____ .

Notes:

Doctor Rita Acupuncture Clinic
17346 Rosewood, Irvine, CA 92612
tel (949) 463-4743 fax(949) 854-4743
http://www.doctor-rita.com
email: info@doctor-rita.com