



# WORKERS' COMPENSATION AUTHORIZATION FORM

## CLIENT COMPANY AUTHORIZATION

This form authorizes a health care provider to treat this employee: \_\_\_\_\_

for a work-related injury which occurred on \_\_\_\_\_

Supervisor's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Company Name \_\_\_\_\_

Address \_\_\_\_\_

Company Phone Number \_\_\_\_\_

## EMPLOYEE AUTHORIZATION

This form authorizes the health care provider treating me to give Employers Resource Management, or their representatives, all information regarding my condition (either orally or in writing), while under your observation or treatment. This information may include history, findings, x-ray readings, diagnosis, and your prognosis as to subsequent or future development; and to photocopy such records as may be requested.

Employee Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## INFORMATION FOR HEALTH CARE PROVIDERS

Employers Resource Management is a co-employer with the company listed above. All Workers' Compensation questions should be referred to the Workers' Compensation Department at (208) 426-8006 or (800) 775-2404. Please speak slowly and repeat your number if you leave a voice mail message.

If you need pre-authorization, or have questions regarding billing, please contact the number below that corresponds with your appropriate state.

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