Date _____

MeM

Work Comp Authorization for Medical Treatment

Employer Information

Employer: _____

Treatment Authorized by: _____

Title: _____

Telephone Number: _____

Injured Employee Information

Employee: _____ Social Security Number: _____

Job Title: _____

Department: _____ Location (s): _____

Date of Injury: _____ Body Part Injured: _____

Work Comp Insurance Carrier: Missouri Employers Mutual Insurance: 1.800.442.0593

Treatment Authorization

Please check all that apply:

- ☐ Initial Evaluation and Treatment
  - ☐ Alcohol Screening
  - ☐ Drug Screening

  Note to employers: *You must have a Drug and Alcohol Policy in place that complies with Missouri law prior to selecting drug and alcohol screening.*
- ☐ Return-to-Work Exam
- ☐ Per Telephone Instructions
- ☐ Other _____

Remarks: _____

_____

Submit a copy of this completed form to Missouri Employers Mutual by fax at 1.800.442.0597 or email it to claims@mem-ins.com.

Place this completed form in the Injured Employee Kit to go to the treating physician.