



MEDICAL CARE AUTHORIZATION FORM

TO BE COMPLETED BY EMPLOYER

Employee Name _____

Nature of Injury _____

Date of Injury _____ Time of Injury _____

Doctor _____ Appointment Date _____

Clinic/ Hospital _____

Address _____

Date _____ Authorized Signature _____

Title _____

TO BE COMPLETED BY PHYSICIAN

Diagnosis _____

Treatment _____

O.K. to return to regular duty on _____

Return to see me on _____

O.K. to work light duty beginning _____

With the following limitations _____

Unable to return to work until _____

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are correct and complete.

Physicians Signature _____

This financial authorization applies to initial evaluation only. Any subsequent treatment, diagnostics, or referrals need to be preauthorized by Consolidated Benefits Resources.

PLEASE FORWARD THE COMPLETED ORIGINAL FORM AND YOUR BILL DIRECTLY TO:

Consolidated Benefits Resources, L. L. C.
P.O. Box 581630
Tulsa, OK. 74158-1630
(918) 594-5170
(800) 826-0419 (toll free)
(918) 594-5171 (fax)
(888) 594-5171 (toll free fax)

RETAIN COPY FOR YOUR FILE

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

REV 04/21/00