MAIN STREET MEDICAL

93 Main Street, Hilton Head Island, SC 29926
Phone: 843 681-3777 / Fax: 843 681 – 9996

WORKERS COMPENSATON AUTHORIZATION FORM

Employee:_____ Date: _____

Employer: _____ Contact Person: _____

Address:_____

Phone: _____ Fax: _____

Date and Time of Accident: _____ Employee SSN: _____

Nature of Injury: _____

Employer agrees to pay claims directly: yes or no

Or

Submit Claims to:

WC company name :_____
Mailing address:_____
_____
WC contact person:_____
Phone: _____
Fax: _____

Claim Number (**REQUIRED**):_____

Is drug screen required: Yes or No

This is to authorize the evaluation/treatment of the above listed injured worker and date(s) of service. If the worker's compensation company denies the claim, the employer agrees to pay the balance on the account for unpaid services provided to the patient.

_____ _____
Authorized Signature Date