

MEDICAL CARE AUTHORIZATION FORM

Approved First Responder Facility

Xpress Wellness Urgent Care
550 W. Shawnee St.
Muskogee, OK 74401
918-910-5186

After Hours

Saint Francis Hospital - Muskogee
300 Edna M. Rockefeller Drive
Muskogee, OK 74401
918-682-5501

TO BE COMPLETED BY EMPLOYER

Employee Name _____

Nature of Injury _____ Body Part(s) _____

Date of Injury _____ Time of Injury _____

Authorized Personnel Signature _____ Date: _____

Title: _____ Employer: **Northeastern State University, Office of Safety Services**

Phone: 918-444-2426

Fax: 918-458-2436

Instructions for Physician

Please perform:

Urine Drug Screen- 9 Panel Send Out

Breath Alcohol (non-Dot)

Reason for testing Post Accident/Reasonable Suspicion Observed/Not obtained

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 _____

(Note: It is the philosophy of this company to provide modified duty work when possible.)

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.

Physician's signature _____ Date: _____

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

Prescriptions: If prescriptions are appropriate, please give the patient a written prescription. Prepackaged prescriptions are not authorized.

PLEASE FORWARD YOUR BILL AND RECORDS TO:

**Rising Medical Solutions
Attn: Consolidated Benefits Resources (CBR)
Post Office Box 572, Milwaukee, WI 53201
Telephone: 866-274-7464**

**Employee-Please return completed form to University Policy Department attn: Safety Services*