Injury Reporting

Work Comp Authorization for Medical Treatment Form

DATE: ____________________

Employer Information

EMPLOYER: ____

____

____

TREATMENT AUTHORIZED BY: ____

TITLE: ____

TELEPHONE NUMBER: ____

Injured Worker Information

INJURED WORKER: ______________________ 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
- ☐ Return-to-Work Exam
- ☐ Per Telephone Instructions
- ☐ Other

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.*

REMARKS: ____

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Submit a copy of this completed form to MEM by fax at 1.800.442.0597 or email it to claims@mem-ins.com. Keep a copy of this form for your records and one for the treating physician.