Injury Reporting
Work Comp Authorization for Medical Treatment Form

DATE: _____

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
- ❒ 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: _____

_____

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.