EMPLOYER AUTHORIZATION FOR MEDICAL SERVICE

This will serve as our request for you to treat the injured employee as shown below. We will work closely with the medical provider to ensure that our employees receive quality medical care that is necessary and provided in a timely manner for industrial injuries. In the best interest of our employees, we often have modified work available that will allow the employee to return to work at the earliest date. Please keep this in mind as you treat our employee.

EMPLOYER INFORMATION	
Employer Name: Southeast Enterprise Holdings, LLC	**Policy #: WC-75185**
Workplace Address:	**Phone #:**
Authorized by Name:	**Title/Position:**

INJURED EMPLOYEE	
Name:	**Social Security Number:**
Date of Birth:	**Occupation:**
Home Address:	
Date of Accident:	**Body Part Injured/injury type:**

Substance Abuse Test:	NO	YES

INSURANCE INFORMATION	BILLING INFORMATION
Ascendant Commercial Insurance Inc. **Claims administered by:** Ascendant Claims Services PO Box 141739 Coral Gables, FL 33114 Tel: 877-834-4991, Fax: 877-834-4994	**Please send bills/claims to:** **CorVel Corporation** **P. O. Box 6966** **Portland, OR 97228**

This form does not confirm that the injury or condition is covered by Workers' Compensation insurance. The determination will be made once the claim representative completes the investigation. Please contact us at (877) 834-4991 PRIOR to one of the following occurrences:

*Anticipated disability in excess of seven (7) days
*Prior disability, by history, of the same body part
*Fracture of a major bone/non-union fracture
*Anticipated permanent disability
*Referral to another provider
*Anticipated surgery
*Hospitalization
*Physical therapy recommended
*Treatment plan to exceed two (2) weeks

Knowingly making a false oral or written statement for the purpose of obtaining or denying benefit or payment is a felony punishable as provided in s. 775.082, s. 775.083, and s. 775.084 of the Florida Statutes.