XPRESS URGENT CARE

Account #__________________

Worker's Compensation Authorization Form

Date: _________________ Xpress Location: ____

Front Desk Staff	
Patient Name:	Date of Birth:
Social Security Number (SSN): __________________ - __________ - __________________ *(Please be advised the claim may be denied without a SSN for verification)*	
*** Date of Injury:	Employer Name:
Xpress Corporate Care? ☐ No ☐ Yes	Authorized By (Name & Title):
Employer Phone Number:	Employer Email:
Employer Billing Address:	

Employer Questions	
Has this claim been reported to the W/C insurance?	
**Authorized Body Part(s):	
**Worker's Comp Insurance Carrier Name & Claims Address:	
**CLAIM NUMBER:	**Adjustor First & Last Name:
**Adjustor Phone Number:	**Adjustor Email / Fax:
Are medications required to be sent to a specific pharmacy?	Specify:
Is a drug screen required?	
If applicable, please mark off all that apply *(refer to Chain of Custody form)* : ☐ LabCorp ☐ Quest ☐ Alere / eScreen ☐ 5 Panel ☐ 7 Panel ☐ 10 Panel ☐ 12 Panel ☐ DOT ☐ Breath Alcohol Test	
Send DWC-25 to (list all that apply):	

***Be sure to document in Case Manager in the patient's chart.

Notes: