XR EXTREME REACH

Medical Treatment Authorization Form

This is an authorization to provide medical services to:

Employee Name (First, Last)	DOB	SSN

EMPLOYEE INFORMATION			
Employer Name	Contact		
Address		Phone	Fax
If deemed first aid please remit bills directly to XR Extreme Reach			
INSURANCE INFORMATION			
Carrier	Policy Number		
Policy Dates			
Please follow up in 48 hours for a claim number.			
PATIENT INFORMATION			
Body Part(s) Injured			
AUTHORIZATION			
Authorizer Name	Authorizer Signature		
Title	Date		

Workers' Compensation fraud is a felony offense. If you have any suspicions regarding the legitimacy of a claim, please notify the XR Extreme Reach Risk Management department immediately.

Questions? Get in touch at riskmanagement@extremereach.com

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