Business Health Partners

"Partners with Business and Industry"

AUTHORIZATION FOR TREATMENT

Please fax to 337-310-1678
Scan/email to authorization@businesshealthpartners.com

Date: _____

Name of Company: _____

Representative Approving Treatment: _____ Email: _____

Jobsite Contact & Phone # for follow up on patient: _____

Fax # _____

Patient Name: _____

DATE OF INJURY: _____

*This note authorizes the above patient to be seen and treated by Business Health Partners for the injury/illness which occurred on the above date. ***In the event of an after-hours fee, that is not paid 100% by the insurance company, the unpaid balance will be billed to your company for payment. In addition, any remaining charges not paid, according to Louisiana Workers Compensation fee schedule, will be the company's responsibility.***

_____
Signature of Representative

Person to contact for further treatment: _____

Telephone/Fax Number: _____

Email: _____

******Post Accident Testing required******
(Circle your selection)

Drug Screen	Non-DOT	DOT	Quick Test __2__5__9__10__12
Breath Alcohol	Non-DOT	DOT	

An Occupational Medicine Clinic
3649 South Beglis Parkway • Sulphur, LA 70665 • (337)-626-1011 • Fax (337)-626-0656