AUTHORIZATION FOR MEDICAL SERVICES

Date _____

Patient Name _____ Patient Date of Birth _____

Company Name _____ Social Security No. _____

❑ Physical Exam ❑ TB Test ❑ Pre-Employment Drug Screen ❑ with alcohol ❑ without alcohol ❑ Post-Accident Drug Screen ❑ with alcohol ❑ without alcohol

TREATMENT FOR INJURY

Injury: _____

Worker's Comp. Insurance Carrier

Street Address

City, State, Zip

( ) Telephone Number ( ) Fax Number

Policy Number

EMPLOYMENT SERVICES

Company Name

Street Address

City, State, Zip

( ) Telephone Number ( ) Fax Number

EMPLOYER MUST SUBMIT REPORT OF INJURY (Form 5020) TO WORKER'S COMPENSATION CARRIER WITHIN THREE (3) DAYS OF THE INITIAL INJURY

AUTHORIZATION

On behalf of the above-named company, I hereby authorize Family Care Centers to provide services as indicated above.

Authorized By ( ) Telephone Number

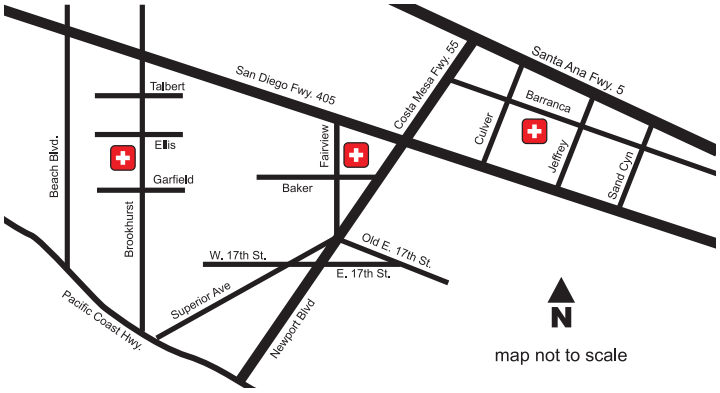
Title/Department ( ) Fax Number

THIS FORM MUST BE PRESENTED TO FAMILY CARE CENTERS AT TIME OF SERVICE

FORM MUST BE SIGNED!

FAMILY CARE CENTERS MEDICAL GROUP INC

www.fccmg.com



Costa Mesa

Hoag Health Center
1190 Baker Street, Suite 100 *(at Fairview Road)*
Phone (714) 668-2500 Fax (714) 668-2515
8:00 a.m. to 8:00 p.m. Mon.-Fri.

Fountain Valley

Niagara Health Center
18785 Brookhurst Street, Suite 101
Phone (714) 378-0042 Fax (714) 968-9129
8:00 a.m. to 8:00 p.m. Mon.-Sat. and 8:00 a.m to 5:00 p.m. Sun

Irvine

Woodbridge Medical Building
4950 Barranca Parkway, Suite 104
Phone (949) 857-1248 Fax (949) 559-1165
8:00 a.m. to 8:00 p.m. Mon.-Sat. and 8:00 a.m to 5:00 p.m. Sun