# TREATMENT AUTHORIZATION

AUT

U.S. HealthWorks MEDICAL GROUP
A Dignity Health Member

*We are authorizing the below listed U.S. HealthWorks(s) to provide treatment to our employees. By doing so, we acknowledge that if the claim is denied by our insurance carrier, we will notify USHW of the denial and will be responsible for payment for all services rendered and any medically-necessary items dispensed.*

1. **UNION CITY** (M-F: 8am-5pm)
   33560 Alvarado Niles Rd
   Union City, CA 94587
   Ph (510) 489-8700 Fx (510) 489-2643

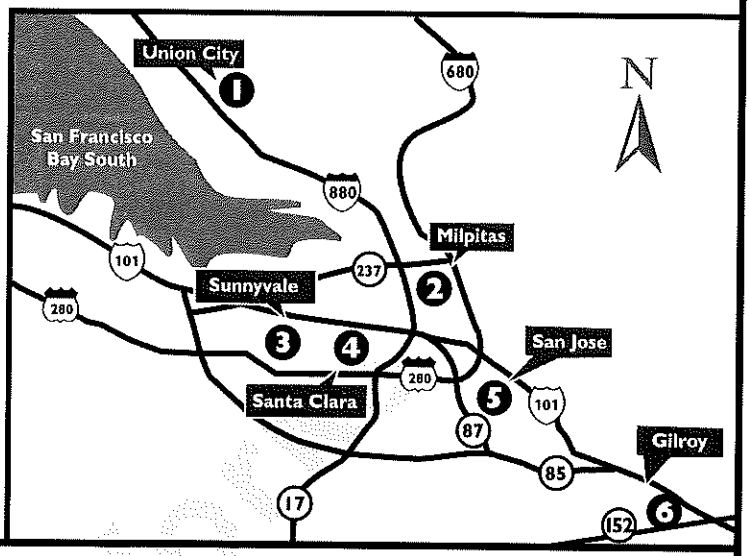
2. **MILPITAS** (M-F: 8am-5pm)
   1717 S Main St, Milpitas, CA 95035
   Ph (408) 957-5700 Fx (408) 946-5476

3. **SUNNYVALE** (M-F: 7am-5pm)
   1197 E Arques Ave, Sunnyvale, CA 94085
   Ph (408) 773-9000 Fx (408) 732-2906

4. **SANTA CLARA** (M-F: 8am-5pm)
   988 Walsh Ave, Santa Clara, CA 95050
   Ph (408) 988-6868 Fx (408) 492-9825

5. **SAN JOSE** (M-F: 7am-7pm, Sat: 9am-4pm)
   1887 Monterey Rd, Ste 200
   San Jose, CA 95112
   *(Same building as American Barbell)*
   Ph (408) 288-3800
   Fx (408) 288-3812

6. **GILROY** (M-F: 8am-5pm)
   190 Leavesley Rd, Gilroy, CA 95020
   Ph (408) 848-0444 Fx (408) 848-0443




Company Name _____ Employer # _____

Primary Contact Name _____

Address Line 1 _____

City _____ State _____ Zip _____

Ph _____ Fx _____

Ph (after hrs/cell) _____ Email _____

## EMPLOYEE DETAILS

PATIENT NAME: _____ DATE: _____ TIME: _____ AM / PM

DEPARTMENT: _____ POSITION: _____

DOES EMPLOYEE WORK FOR A TEMP/LEASING COMPANY? ❑ YES ❑ NO NAME OF TEMP AGENCY: _____

AUTHORIZED BY: NAME (print): _____ PHONE: _____

TITLE: _____ AFTER HRS / CELL PHONE: _____

SIGNATURE: _____ ( ) VERBAL AUTHORIZATION

## INSURANCE

INSURANCE COMPANY NAME: _____

CLAIMS ADDRESS: _____

PHONE: _____ EFFECTIVE DATE: _____

POLICY #: _____ EXPIRATION DATE: _____

## SERVICES

O INJURY: DATE OF INJURY: _____ LAST WORKED: _____

INJURED BODY PART: _____ CLAIM #: _____

O RETURN-TO-WORK EVALUATION: _____

O PHYSICAL EXAM TYPE: _____ PROTOCOL #: _____

O DRUG/ALCOHOL TEST - specify type and reason/purpose below: PROTOCOL #: _____

**TYPE:**
- ❑ DOT DRUG TEST
- ❑ DOT BREATH ALCOHOL TEST
  Agency (required): _____
- ❑ NON-DOT DRUG TEST
- ❑ NON-DOT BREATH ALCOHOL TEST
- ❑ INSTANT DRUG TEST

**REASON/ PURPOSE:**
- ❑ PRE-EMPLOYMENT
- ❑ RANDOM
- ❑ REASONABLE SUSPICION
- ❑ POST-ACCIDENT
- ❑ RETURN TO DUTY
- ❑ FOLLOW UP
- ❑ POST-INJURY

Perform test before: Date: _____ Time: _____ AM / PM

*** PICTURE ID REQUIRED FOR DRUG TEST**

Rev 02/08/2018