NORTHERN INDIANA
HAND&WRIST
CENTER

EMPLOYER'S AUTHORIZATION FOR TREATMENT OF OCCUPATIONAL INJURY

EMPLOYEE INFORMATION

Employee Name: ______________________ Date of Birth: ______________________

Employee Address: ______________________ Employee Phone: ______________________

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EMPLOYER INFORMATION

Employer Name: ______________________ Supervisor: ______________________

Employer Address: ______________________ Employer Phone: ______________________

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Has First Report of Injury Been Filed: Yes No

BILLING INFORMATION

☐ This condition/injury is work-related and, therefore, covered by the IN Worker's Compensation Act

☐ Bill the worker's compensation carrier as follows:

Insurance Carrier: ______________________ Claim #: ______________________

Carrier Address: ______________________ Adjuster Name: ______________________

______________________ Adjuster Phone: ______________________

INJURY INFORMATION

Type of Injury: ______________________

Date of Injury: ______________________

Time of Injury: ______________________

AUTHORIZATION FOR TREATMENT

Authorized By: ______________________ Title: ______________________
Print Name

Signature: ______________________ Date: ______________________