TREATMENT AUTHORIZATION FORM

For Workers' Compensation Injury - Archdiocese of St. Louis

This form is to be **COMPLETED* and SENT with the INJURED EMPLOYEE** to the OCCUPATIONAL HEALTH AND MEDICINE DEPARTMENT of one of the pre-approved providers.

*Send a copy of this form and the Missouri Report of Injury form to BrandonRothkopf@archstl.org (or fax 314-792-7079)

Locate an approved provider at: www.talispoint.com/cvty/gbppo OR call 1-314-965-7810 for assistance from Candace Langbecker or Patricia McGlassion at Gallagher Bassett.

INJURED EMPLOYEE'S INFORMATION

NAME:			
ADDRESS:			
PHONE #:	( )	DATE OF BIRTH:	___/___/_____ MM / DD / YYYY
SOC. SEC. #:			
DATE OF INJURY:	___/___/_____ MM / DD / YYYY	INJURED PART(S) OF THE BODY:	
DESCRIPTION OF ACCIDENT:			

PARISH / SCHOOL / AGENCY INFORMATION

NAME OF PARISH / SCHOOL / AGENCY:			
ADDRESS:			
PHONE #:	( )		
TREATMENT AUTHORIZED BY:		Signature*:	
***Form must be signed by a properly designated representative of the Parish/School/Agency (not the injured employee)**		Printed name:	

MEDICAL CARE PROVIDER'S INFORMATION

FACILITY/ PHYSICIAN'S NAME:			
FACILITY ADDRESS:			
PHONE #:	( )	APPOINTMENT DATE:	___/___/_____ MM / DD / YYYY

MEDICAL STAFF - Please COMPLETE the section below and FAX this form to 866-947-2227, ATTN: Candace Langbecker OR mail to: Gallagher Bassett, 1630 Des Peres Rd, Suite 140, St. Louis, MO 63131

DIAGNOSIS: _____

TREATMENT RECOMMENDATIONS: _____

RETURN TO WORK STATUS: Light Duty / Full Duty

ANTICIPATED RESTRICTIONS: _____

PROJECTED DATE FOR COMPLETION OF TREATMENT: ____/____/_____

PROVIDER'S SIGNATURE: _____ DATE: _____

Send bills to: Gallagher Bassett Services P.O. Box 2831, Clinton, IA 52733-2831

Gallagher