Claims | Claims Management of Missouri, LLC
Mgmt of MO

# MEDICAL TREATMENT AUTHORIZATION
## Workers' Compensation
## Post Accident - Drug / Alcohol Testing

**Date:** _____

**Patient Name:** _____

**Company:** _____

**Date of Loss:** _____

**Body Part:** _____

***(Photo ID Required)***

**Drug Screen: (non-DOT)** **YES** _____ **(initials)**

**Alcohol Screen: (breath OR urine acceptable)** **YES** _____ **(initials)**

****** Results to be faxed immediately to: _____******
**Attn: _____**

**Authorized By:** _____
**(Company Signature)**

**Printed Name:** _____
**On behalf of Company:** _____

**Phone Number:** _____