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: _____