THOMPSON INSURANCE, INC.
AGENTS AND BROKERS

TREATMENT AUTHORIZATION FORM

Form to be presented to physician's office for treatment.

EMPLOYEE INFORMATION

(Valid identification is needed for all drug screens and breath alcohol tests)

Name: _____ Position: _____ Date: _____

SCREENS REQUIRED UPON TREATMENT: _____ Breath Alcohol Test _____ Instant Drug Test

EMPLOYER INFORMATION AND AUTHORIZATION

AUTHORIZED TREATMENT PROVIDER: _____

SUPERVISOR NAME: _____ OFFICE: _____

CONTACT PERSONNEL: _____OR _____

Please call _____ at _____ after treatment

AUTHORIZATION: This form, completed and signed by an authorized representative of _____, serves as authorization to treat the above named employee and to bill for services rendered.

Authorized Signature: _____ **Date**: _____

BILLING INFORMATION

Submit all billing to: