Treatment Authorization

Treatment Overview

Option A: Jobsite Injury ☐ **Option B: Additional Services Only** ☐

(Please select one of the two options above).

Section 1: Employee Information

Employee Name: _____ Today's Date: _____

Center Location: _____ Injury location: _____

Date of Injury: _____ Time of Injury: _____

Injury Details (body parts injured – please list what was injured):

_____

_____

Section 2: Employer Point of Contact Information (billing or questions)

Employer: ImmunoTek Bio Centers Employer POC: Allison Southmayd

Email: wc@immunotek.com Phone: 817-961-1790

Address: Attn: Workers Comp. 1430 E Southlake Blvd # 200, Southlake, TX 76092

***Please send all invoices to wc@immunotek.com

Section 3: Additional Services

Drug Screen: (Yes or No). Type of Drug Panel: _____

Hepatitis B Vaccine: _____ (Yes or No).

Section 4: Additional Comments

_____

_____

Section 5: Authorization

Manager Print First and Last Name: _____

Manager Authorization Signature: _____ Date: _____