43475 Dalcoma Dr., Suite 250
Clinton Township, MI 48038
Phone: (586) 436-3785 | Fax: (833) 972-5451

Employer Authorization for Treatment

This form authorizes Movement Orthopedics to provide medical treatment for a work-related injury under workers' compensation.

Employee Information

Employee Name: ______________________ **DOB:** ______________

Date of Injury: ______________ **Claim Number:** ______________________

Employer Information

Company Name: ______________________________________

Address: ____

Contact Person: ______________________ **Title:** ______________

Phone: ______________ **Email:** ______________________

Insurance Carrier Information

Carrier Name: ______________________________________

Adjuster Name: ______________________ **Phone:** ______________

Claim Number: ______________________ **Policy Number:** ______________________

Authorization

I, the undersigned, authorize Movement Orthopedics, PLLC to provide medical evaluation and treatment for the above-named employee for a work-related injury. The employer and/or its workers' compensation insurance carrier agrees to be responsible for payment of all authorized medical services rendered.

This authorization is valid for the duration of the workers' compensation claim unless revoked in writing.

____________________________________ ____________________________________

Employer Representative Signature Date

Printed Name: ______________________ **Title:** ______________