SouthStar URGENT CARE™

Form #126

GoSouthStar.com

POST ACCIDENT AUTHORIZATION FOR SERVICES

COMPANY: _____

DRUG SCREEN: YES _____NO _____
QUICK SCREEN: YES _____NO _____
BAT: YES _____NO _____

DOT NON-DOT

PATIENT NAME: _____ **DATE OF REFERRAL:** _____/_____/_____

DATE OF ACCIDENT: _____/_____/_____ **TIME OF ACCIDENT:** _____AM / PM

NATURE OF INJURY: _____

SPECIAL BILLING INSTRUCTIONS: _____

CALLED IN BY: _____ **TIME:** _____AM / PM

COMPANY PHONE#: _____ **FAX#:** _____

WAS PATIENT SEEN ELSEWHERE? YES / NO IF YES, GIVE PLACE AND DATE SEEN:

_____
_____
_____

SPECIAL INSTRUCTIONS:

_____
_____
_____

COMPANY CONTACT UPON COMPLETION: _____

PHONE# _____ **CELL#** _____

EMAIL: _____

COMPANY CONTACT IN LOBBY: YES / NO