Sacramento Occupational Medical Group

Fidel Realyvasquez, M.D. Medical Director

AUTHORIZATION FOR MEDICAL SERVICES

PLEASE BE PROMPT AND BRING THIS AUTHORIZATION WITH YOU

Patient Name: _____Date: _____Phone: _____

Employer:

_____

Department: _____Position: _____

If Temp, what Agency?

_____

SERVICES REQUESTED:

□ Work-Related Injury Treatment □ Urine Drug Screen, Non-DOT □ Breath Alcohol Test
□ Pre-Placement Physical Exam □ DOT Physical Exam □ DOT Drug Screen
□ Agility Function Test □ Vaccines (Specify Below) □ Blood Work (Specify Below)
□ **Instant Drug Screen** □ **TB Test** □ **Other _____**

FOR DRUG SCREEN OR ALCOHOL TESTS, PLEASE CHECK THE FOLLOWING TYPE:
□ Pre-Placement □ Post-Accident □ Random
□ Return-To-Duty □ Reasonable Suspicion □ Other Screen _____

RESPONSIBLE PARTY:

☐ Employer ☐ Insurance ☐ T.P.A. ☐ Patient

Insurance Company or T.P.A. Name:

_____

Policy or Account # _____Phone: _____

Claim Number: _____Date of Injury (DOI): _____

Employer:

_____

Phone: _____Contact: _____

We are authorizing Sacramento Occupational Medical Group to provide treatment to our employee listed on this form. By doing so, we acknowledge that if the claim is denied by our insurance carrier, we will notify SOMG of the denial and will be responsible for all services rendered and any medically-necessary items dispensed.

Authorized By:

_____