Work Injury Authorization Form

Today's Date:	
Company Name:	
Authorizing Rep:	
Telephone Number:	
Employee Information	
Employee Name:	
Date of Birth:	
Date of Injury:	
Description of Injury:	
Drug Screen:	Yes ☐ No ☐
Billing Information	
Send Billing To:	☐ Workers" Compensation ☐ Employer
Workers' Compensation Carrier Information	
Carrier Name:	
Address:	
City, State, Zip:	
W/C Claim#:	
Case Manager:	
Contact Number:	
Employer Information	
Address:	
City, State, Zip:	
Contact Name:	
Contact Number:	
OHP WorkCare Information	
OHP Representative	
Scheduled Date/Time	

Phone (270) 781-6477 Fax (270) 781-6479 www.ohp-care.com

Submit Form