Ascension Michigan Employer Solutions

After Hours Employer Authorization

For Work Comp Treatment/Billing

Date _____

Employer Name _____

Employee Name _____ _____
Last First

Date of Birth _____ Last 4 digits of SS# _____

This employee is authorized for the following:

Injury Care: (Describe) _____

Date of Injury: _____ Time: _____ a.m. ❑ p.m. ❑

Controlled Substance Test with this Injury: ☐ Urine Drug Screen ☐ Breath Alcohol Test

Patients treated after hours should return for follow-up injury care at Ascension Michigan Employer Solutions

BILL AFTER HOUR VISIT TO:

☐ Employer _____

Address _____
Street City State Zip

☐ Work Comp Carrier _____

Address _____
Street City State Zip

Phone # _____

Claim # (if available at time of visit) _____

AUTHORIZED BY: _____
Please Print Phone

AUTHORIZED SIGNATURE: _____ Date _____

Your Partner in Workplace Health & Wellness
www.employersolutions.ascension.org