Authorization For Medical Treatment For Workers' Compensation

Drug Screen/Blood Alcohol MUST be Performed for ALL Work Comp Injuries

Provider: _____

Company Name: _____

Employee Name: _____

Date of Injury: _____

Type of Injury: _____

_____

_____

Bill To: **BRIDGE HR Staffing**
3477 Corporate Parkway, Suite 100
Center Valley, PA 18034
Attn: Risk
Risk@bridgehrstaffing.com

_____

Signature of Supervisor Date