# EMPLOYER AUTHORIZATION FOR TREATMENT

## Employee

Name:_________________________________

DOB:__________________________________

Date of injury:__________________________

Time of injury:__________________________

Body Part Injured:_______________________

## Drug Screen / Breath Alcohol

(Must be performed within 32 hrs with MRO Review)

10 panel Non-Dot: -YES -NO

Breath Alcohol: -YES -NO

## Employer

Name:_________________________________

Address:_______________________________

______________________________________

Phone #:_______________________________

Fax #:_________________________________

Email:_________________________________

## Worker's Compensation Carrier / TPA

Name: Construction Claims Management, Inc. (CCM, Inc.)

Address: P.O. Box 244202

Montgomery, AL 36124-4202

Phone #: 1-800-372-1801 or 334-834-0283

Fax #: 334-834-9293

Billing Email: ccmmedrecords@hbaa.org

Have you completed a First Report of Injury for your carrier? (This is needed to initiate or process a claim)

Yes__________ No__________

*Authorization for treatment by Employer is not a guarantee of payment from CCM, Inc. / Alabama Homebuilders Self Insurers Fund. Submitted claims and billing are reviewed for coverage and compensability.

## Employer Authorized Signature:______________________________

## Print Name:_____________________________________________

## Date:__________________