# WORKERS' COMPENSATION AUTHORIZATION FOR IMMEDIATE MEDICAL TREATMENT

**Employer Instructions:**
To report injuries, email FirstNotice@icwgroup.com or call 844.442.9252. Complete this form for your employee to give to your designated medical provider. Be sure to keep a copy for your records.

Name of Employer _____ Policy number _____

Address _____ City _____ Zip _____ State _____

Name of insured employee _____

Date of injury _____ Place of injury _____

Body part(s) injured _____

Description of accident _____

Name of person completing this form _____ Title _____

Signature _____ Date _____

Designated medical provider _____ Phone _____

Location _____

**To the Medical Provider:**
This is your authorization to provide medical care to the employee named above. Please treat only injuries related to the accident as described on this form. PLEASE NOTE - This form does NOT guarantee coverage. Coverage must be verified prior to treatment by calling 844.442.9252. After treatment, please forward the attending physician's report and all bills to:

Mitchell Solutions
P.O. Box 2965
Clinton, IA 52733-2965

Fax: 858.586.2444

*Note: If injury was not a result of employment, this form serves only as a request for examination and report.*

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