Workers' Compensation

ICW GROUP Insurance Companies

Authorization for Immediate Medical Treatment

Employer Instructions: To report injuries, email FirstNotice@icwgroup.com or call 855.442.9252. 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	STATE	ZIP	PHONE NUMBER	FAX NUMBER
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 855.442.9252. 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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