

## Authorization for Immediate Medical Treatment

**Employer Instructions:** To report injuries, email [FirstNotice@icwgroup.com](mailto: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.*