AUTHORIZATION FOR INITIAL MEDICAL TREATMENT

1 EMPLOYEE AND SUPERVISOR

Instructions: This form is authorization for an employee of the City of Fort Worth who has been injured on-the-job to receive initial medical treatment only for injury. Instructions:

1. The injured employee should take this form to the initial medical treatment appointment
2. If the injury requires emergency medical treatment, the employee or supervisor should provide it to the emergency treatment facility
3. The form must be signed by an authorized Dept. Medical Records Coordinator, Police Department Policy Analyst, or by HR Risk Management staff
4. Please make a copy of the completed/signed form, and send it via email to: Blackstone@fortworthtexas.gov ; or fax to: 817-887-3012. If you have any questions, please contact HR Risk Management at 817-392-7402.

2 EMPLOYEE ON-THE-JOB INJURY INFORMATION (SUPERVISOR TO COMPLETE)

INJURED EMPLOYEE:	*Last Name*	*First name*	*M.I.*	XXX-XX- SSN Last 4 Digits
DATE OF INJURY:		**Sedgwick CLAIM #:** **(if known)**	Not Assigned	
BRIEF DESCRIPTION OF INJURY:				
CITY DEPARTMENT:		**DIVISION**:		
SUPERVISOR:	*Last Name*	*First name*	*M.I.*	
…… *Authorized Signature of Medical Records Custodian or HR Risk Management Staff*		*Date*	817-392- *Phone*	

3 HEALTH CARE PROVIDER

This is your authorization to provide **initial** medical treatment or services **only** to the above named City of Fort Worth employee. Any subsequent medical treatment should be coordinated with the City's third party administrator for workers' compensation, Sedgwick. **Please send medical reports and invoices for services to:**

Sedgwick Claims Management Services P.O. Box 14572 Lexington, KY 40512	Fax Number for Claims: (859) 264-4367 Fax Number for Preauthorization: (877) 922-7236 Phone Number for Preauthorization: (866) 286-0281

4 PHARMACIST – FIRST FILL INFORMATION

AWPRx has been selected by the City of Fort Worth and its workers' compensation claims administrator, Sedgwick, to provide prescription drugs to employees of the City who sustain an on-the-job injury – See Injured Employee information above. This form authorizes you to fill an initial prescription(s) written by the injured employee's authorized workers' compensation physician for medications related to the on-the-job injury.

AWPRx Bin #: 610237	**Group Number: FTW001 PCN: AWPRX**		**Pharmacy Help Desk: (888) 356-3332**	
P.O. Box 850001	Orlando, FL 32885-0301	Fax: (888) 700-7997	www.forcerx.com	cs@forcerx.com

Member ID:		⇦ **MRC**: Enter employee's last 4 digits of SSN + date of injury (i.e., 999905012016)
Member Name:		⇦ **MRC**: Enter employee's full name
Employer Name:	**City of Fort Worth**	
Date of Injury:		⇦ **MRC**: Enter the date of injury