REQUEST FOR MEDICAL TREATMENT FORM

Part 1: (To be completed by Supervisor)

Employee Name: _____ Social Security No: _____

Date: _____ Supervisor Name: _____

Employer Name: Advantus Corp Supervisor Phone Number: _____

Employer Address: 12276 San Jose Blvd, Suite 618, Jacksonville, FL 32254

Date of Injury: _____ Location of Injury: _____

Injury Description: _____

_____

Insurance Carrier: Zurich Policy Number: 130503

Address:

Zurich
P.O. Box 968070
Schaumburg, IL 60196

Part 2: (To be completed by Employee. Employee should take this form to the Primary Care Physician or treating physician.)

English: I authorize payment directly to the provider for the medical services rendered and I authorize the release of medical information to Carrier/Claim Administrator or its designed for medical review.

Spanish: Autorizo a que se efectue el pago irectamente I proveedor por los servicios medicos prestados, y autorizo la divulgacion de informacion medica a la Compania de Seguros / Administrador de Reclamaciones o a la persona designada para la revision medica.

Employee is required to submit to a mandatory alcohol and drug screen within 24 hours of incident at Medical Treatment Center (or alternate location pending Human Resources Department approval).

Employee Signature: _____ Date:_____

ADVANTUS

PRESCRIPTION AUTHORIZATION

Part 1: (To be completed by Supervisor.)

Employee Name: _____ Social Security No: _____

Date: _____ Supervisor Name: _____

Employer Name: Advantus Corp Supervisor Phone Number: _____

Employer Address: 12276 San Jose Blvd, Suite 618, Jacksonville, FL 32223

Date of Injury: _____

Location of Injury: _____

Injury Description: _____

_____

Insurance Carrier: Zurich Policy Number: 130503

Address:

Zurich Customer Care Center
PO Box 66946
Chicago, IL 60666-6946

Part 2: (To be completed by Employee. Employee should take this form to the Pharmacy.)

English: I authorize payment directly to the provider for the prescriptions services rendered and I authorize the release of medical information to Carrier/Claim Administrator or its designed for medical review.

Spanish: Autorizo a que se efectue el pago irectamente I proveedor por los servicios medicos prestados, y autorizo la divulgacion de informacion medica a la Compania de Seguros / Administrador de Reclamaciones o a la persona designada para la revision medica.

Employee Signature: _____ Date:_____