Advanced Urgent Care

WorkersCompFaxForm

Date: ______________________________

Company Name: ______________________________

Company Address: ______________________________

Phone: ______________________________

Fax: ______________________________

From: ______________________________

# of Pages: ______________________________

Employee name: ______________________________

Employees SS#: ______________________________

Date of Injury: ______________________________

Carrier Name, Address, Phone # ______________________________

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Claim #: ______________________________

*If requesting a drug test, please send a statement on company letterhead requesting the drug test. Include reason for the drug test, list of drugs to be tested for, signature of employer authorizing drug test OR chain of custody.

Have questions? Visit www.24hourAdvancedUrgentCare.com call 708.448.8913 to learn more.