



MEDICAL AUTHORIZATION FORM

Employer: Modern Business Associates L/C/F _____
(Client name here)

Employee Name: _____

This is authorization for medical treatment arising from a job related injury being reported under Workers' Compensation Law. All billing and future authorizations should be directed to MBAvisors at the location shown below.

***** A 10 panel drug screen is required on all work related injuries. Please fax drug screen results, a copy of the COC, along with any office notes to MBAvisors Risk Management Department at 1-888-894-4622. *****

Manager's Signature: _____ Date: _____

Employee's Signature: _____ Date: _____

MBAvisors
Attn: Risk Management Department
9455 Koger Blvd.
Suite 200
St. Petersburg, FL 33702
1.888.622.6460