Medical Treatment Authorization Form

This is an authorization to provide medical services to:

Employee name (First, Last)	DOB	SSN

EMPLOYER INFORMATION	
Employer Name: **Extreme Reach**	Contact: **Aldo Cammarota**
Address: **333 N. Glenoaks Blvd. Suite 301, Burbank, CA 91502**	
Phone: **(w) 818.568.1801 or (m) 818.217.5941**	Fax: **818.562.3301**
If deemed first aid please remit bills directly to Extreme Reach.	

INSURANCE INFORMATION	
Carrier: **ACE American Insurance Company**	Policy Number: **Contact Aldo Cammarota**
Policy Dates: **09/01/2023 - 09/01/2024**	
Please follow up in 48 hours for a claim number.	

PATIENT INFORMATION
Body Part(s) Injured:

AUTHORIZATION	
Authorizer Name:	Authorizer Signature:
Title:	Date:

Workers' Compensation fraud is a felony offense. If you have any suspicions regarding the legitimacy of a claim, please notify the Extreme Reach Risk Management department immediately.

Questions? Get in touch at riskmanagement@extremereach.com