

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: 09/01/2021 - 09/01/2022	
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@extimereach.com