Date:
West Hills Hospital/ Grossman Medical Group
7300 Medical Center Drive
West Hills, CA 91307
Via FAX: # 818-676-4001

Re: Claimant:
Employer:
Claim #:
Date of Injury:

Authorization for Treatment

Dear Provider,
This notice shall serve as an Authorization for evaluation and treatment for (name of patient), (Date of Birth) under the work compensation claim.
Please commence scheduling the authorized treatment as quickly as possible but please let us know if there is anything else you need.

Employee Demographics:
Address:
Phone #:

Accepted Body Part:

Please submit all medical billing to the following address for payment:
Address of work comp insurance company:

Sincerely.
Name of claim specialist: