EMPLOYER'S APPROVAL FOR MEDICAL ATTENTION

Employee's Name: _____

Employer: _____

Date of Injury: _____

Part(s) of Body Injured: _____

Employer-Designated Treating Physician or Facility: _____

_____

Employee: Please take this form with you to medical facility indicated above.

Notice to Preferred Provider: This letter will serve as approval for the above-named employee to receive initial treatment required to cure or relieve him or her from the effects of their industrial injury. Our Third Party Administrator reserves the right to determine if further treatment is work-related and/or reasonable or necessary.

Please submit the Doctor's First Report of Injury, Form 5021, to:

LWP Claims Solutions, Inc
PO Box 349016
Sacramento, CA 95834-9016

Phone: (916) 609-3600
Fax: (916) 720-0533