



A member of the PMA Insurance Group

This is a Worker's Compensation Treatment Authorization Form. This Form is not a guarantee of eligibility or compensability for Workers' Compensation Benefits.

To be completed by employer (please print)

Account Number: 2499309

Employer Name: _____

Employer Address: _____

Employee Name: _____

Social Security Number: _____ Date of Injury: _____

Type of Injury: _____

Body Part Injured: _____

Supervisor issuing form: _____

Supervisors: Please give this completed form to the injured employee to take with them to the physician. You must file the First Report of Injury with the PMA Insurance Group within 24 hours of injury.

This form is for one time use, only on this date _____.

Providers: You must call The PMA Insurance Group toll free at 888-476-2669 prior to any additional treatment/admission or referral, other than an emergency situation. In an emergency situation, notification to PMA is required within 24 hours.

	<p><u>Send Medical Bills To:</u></p> <p>PMA-Medical Bill P.O Box 2854 Clinton, IA 52733-2854 1.888.476.2669 P 1-888-329-2721 F</p>	
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