Initial Authorization for Treatment

Authorization Date:

Employee Information:

Employee Name: Date of Birth:
Employee Address:
Phone Number: Email:

Employer Information:

Name of Court:
Court Contact Person:
Court Address:
Phone Number: Email:

Insurance / Claims Administrator:

Insured by: Judicial Branch Workers' Compensation Program Policy #: JBWCP
Claims Administrator: Sedgwick CMS
Claims Phone:
Send Bills to:
Send Requests for Authorization to:
Find a Provider/Specialist:

Work Related:

☐ Injury Date of Injury or Illness:
☐ Illness Modified / Transitional Duty Available: Yes
Claim Number (if known):
Description of Incident or Work-Related Illness:

Special Instructions or Comments:

I authorize the medical provider to provide initial medical treatment to the employee named above.

Signature: Date:
Name: Position / Title: