

# Medical Treatment Authorization Form

This is an authorization to provide medical services to:

\_\_\_\_\_  
Employee name (First, Last)

\_\_\_\_\_  
DOB

\_\_\_\_\_  
SSN

EMPLOYER INFORMATION	
Employer Name: <b>Extreme Reach Talent</b>	Contact: <b>Aldo Cammarota</b>
Address: <b>3330 Cahuenga Blvd W., 4th Fl, Los Angeles, CA 90068</b>	
Phone: <b>(w) 818.568.1801 or (m) 818.217.5941</b>	Fax: <b>818.562.3301</b>
If deemed first aid please remit bills directly to Extreme Reach Talent	
INSURANCE INFORMATION	
Carrier: <b>ACE American Insurance Company</b>	Policy Number: <b>Contact Aldo Cammarota</b>
Policy Dates: <b>09/01/2020 - 09/01/2021</b>	
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 [aldo.cammarota@extremereach.com](mailto:aldo.cammarota@extremereach.com)