**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