

MEDICAL SERVICE ORDER

Doctor Name: _____

Address: _____

Employee Name: _____ was injured on
_____ while in our employ.
(Date) (Time)

Please render necessary medical treatment immediately, then complete and forward
the Doctor's First Report Of Occupational Injury Or Illness to:

ACWA/Joint Powers Insurance Authority
c/o Manageware
PO Box 6510 Mesa, AZ. 85216
(800) 231-5742 FAX (916) 965-6847
Provider Fax # for RFA Intake (602) 536-0905

Employer: _____

Address: _____

Employer Representative: _____ Date: _____

One time visit only - call ACWA/JPIA for authorization

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