

➤ Medical service order

Employer: Complete and sign this form and give to employee

Employee: Give the completed form to the clinic/physician

Doctor/Clinic name:

Doctor/Clinic address:

We are sending (employee name) _____ to you for an evaluation and treatment relative to a work related injury sustained on (date of injury) _____.

Please submit your Doctor's First Report of Injury, any subsequent medical reports and bills to:

York Risk Services Group

P.O. Box 619079
Roseville, CA 95661
P. 800.922.5020
F. 866.548.2637

UR Referral: ALL RFA-UR Referral

California fax to: 800.618.1439
All other states fax to: 800.580.3121
E. urintake@careworks.com

Employer name:

Signature:

Print name and title:

Phone number:

We value our employees and make every effort to accommodate any work restriction imposed. Please delineate work restriction(s).