PO Box 945927
Maitland, FL 32794-5927
321-214-5350 • Fax 321-214-0235
800-226-0666 • ffvamutual.com

Date: _____

INITIAL TREATMENT AUTHORIZATION

To: Medical Facility: _____

From: Employer: _____

RE: Claimant : _____
DOB : _____
SSN : _____
D/A : _____
Claim # : AIM-_____

If this claim is determined to be the direct result of a compensable work related injury, your services for initial medical treatment will be authorized. If this injured worker requires additional medical treatment and/or referral, documentation is required to determine authorization.

Please submit your bill and report to:

FFVA Mutual
P.O. Box 945927
Maitland, FL 32794

Phone: 800-226-0666
Fax: 321-214-0235

Treatment Date: _____

Work status: ____ Full Duty ____Light Duty ____No Work

Restrictions: _____

Diagnosis: _____

Next Office Visit: _____

_____ _____
Physician's Signature Date

Please provide the claimant with a copy of this completed form.
Thank you for your attention to the above.