



Wellness Center
1174 Live Oak Boulevard • Yuba City, CA 95991
(530) 822-5500 • Fax (530) 822-5503

AUTHORIZATION FOR SERVICES

Employer Name: _____

Service Recipient: _____
First Name / Last Name

Personify ID #: _____

This form is for use by participating TCSIG employers who are sending employees who do not participate in TCSIG's medical plan.

- | | |
|---|----------------------------|
| <input type="radio"/> TB Risk Assessment | \$10 per person |
| <input type="radio"/> TB Test | \$30 per person |
| <input type="radio"/> TDap | \$60 per person |
| <input type="radio"/> FLU VACCINE | \$30 per person |
| <input type="radio"/> HEP A IMMUNIZATION | \$78 per person |
| <input type="radio"/> HEP B IMMUNIZATION SERIES (Series of 3 shots) | \$210 per person |
| <input type="radio"/> MMR | \$90 per person |
| <input type="radio"/> EMPLOYEE PHYSICAL | \$100 per person |
| <input type="radio"/> 2pk Epinephrine Auto Injector Jr .15mg | \$240 per pack |
| <input type="radio"/> 2pk Epinephrine Auto Injector Adult 3mg | \$240 per pack |
| <input type="radio"/> HEP B IMMUNIZATION SERIES (Series of 3 shots) | Workers' Comp Participants |
| <input type="radio"/> OTHER REQUESTED SERVICES: | Cost Determined By Service |

(Specify other service as confirmed after calling (530)822-5500)

As a member of the TCSIG Joint Powers Authority, we hereby authorize the provision of the Wellness Center personnel to provide the following services and agree to reimburse TCSIG

Authorizing Signature: _____

Print Name: _____

Date: _____ Phone Number: _____

Medical Services Provided by Acorn Health Group

Wellness Center:

Date Service Received: _____ By: _____