

**Spartanburg County  
Workers' Compensation Authorization**

The injured employee should present this form to the doctor, hospital or clinic when reporting for an appointment.

This form, provided by Spartanburg County, authorizes the first visit and first prescription related to the accident described below. The Department Head/Supervisor should give initial authorization. The Claims Administrator, **Ariel TPA**, must give further authorization. Their phone number is **1-855-222-6379**. Claims Adjusters and their extensions are:

**Rachael Stephenson, ext. 175      Crystal Jeffcoat, ext. 153**

If the Claims Administrator is unavailable, please call the Spartanburg County's Benefits Specialist, **Stephany Smith, at 864-596-3543**

<b>Employee:</b> _____	<b>Department:</b> _____
<b>DOB:</b> _____	<b>Social Security #:</b> _____
<b>Accident Date:</b> _____	<b>Type of Injury:</b> _____
<b>Contact /Supervisor:</b> _____	<b>Phone #:</b> _____

**Send bills and medical reports (including release to return to work) to:  
Ariel Third Party Administrators, Inc.  
Post Office Box 212159  
Columbia, SC 29221  
(Phone) 1-855-222-6379 (Fax) 1-803-365-0098**

**RETURN TO WORK**

(To be completed by Doctor after employee's examine)

Medical Clinic or Office: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of First Treatment: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Date of Accident and Description of Accident Per Employee: \_\_\_\_\_

Please advise:

\* Employee **IS ABLE** to return to regular duties at this time: \_\_\_\_\_

\* Employee **IS ABLE** to return to work with the following restrictions: \_\_\_\_\_

\* Employee **IS UNABLE** to return to work until: \_\_\_\_\_

Projected Dates of Return to: **Regular Duties:** \_\_\_\_\_ **Light Duties:** \_\_\_\_\_

Next Appointment Date/Time: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date