TCSIG Members' WELLNESS CENTER

AUTHORIZATION FOR WELLNESS CENTER SERVICES

EMPLOYER NAME: _____

***SERVICE RECIPIENT:** _____
(First Name) (Last Name)

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 for said services within 30 days of receiving a billing.**

O TB Test	$10 per person
O TDap	$46 per person
O FLU VACCINE	$25 per person
O HEP A IMMUNIZATION	$78 per person
O HEP B IMMUNIZATION SERIES (Series of 3 shots)	$210 per person
O MMR	$67 per person
O EMPLOYEE PHYSICAL	$75 per person
O SPECIFY OTHER REQUESTED SERVICES	cost determined by service

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

Authorizing Signature: _____

Print Name: _____

Date: _____ Phone Number _____

* This form is for use by participating TCSIG employers who are sending employees who do not participate in TCSIG's medical plan for the above listed services.
** Reimbursement charges may vary based on supply or other factors