



## 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.\*\*

- TB Risk Assessment \$ 5 per person
- TB Test \$10 per person
- TDap \$46 per person
- FLU VACCINE \$25 per person
- HEP A IMMUNIZATION \$78 per person
- HEP B IMMUNIZATION SERIES \$210 per person  
(Series of 3 shots)
- MMR \$67 per person
- EMPLOYEE PHYSICAL \$75 per person
- 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