NOVANT HEALTH
URGENT CARE

Occupational Medicine/WKC Authorization Form (for Employer)

Complete this form (all fields) and present at time of service

Patient Name	Employer Phone	Employer Fax	Date
Employer Name	Primary Contact		
Employer Address	Email		

ALL EMPLOYERS - SELECT ALL AUTHORIZED SERVICES *** Employee must bring this completed form for services to be rendered***

☐ Drug Screen Non-DOT # Panels: _____	☐ TB/PPD (Skin Test)	☐ Hepatitis B Titer
☐ Drug Screen DOT Panel	☐ QuantiFERON – TB (Q Gold)	☐ Varicella Titer
☐ Urine Collection Only	☐ Pre-Employment Physical	☐ Rubella Titer
☐ Breath Alcohol Test	☐ Occupational Health Physical	☐ Rubeola Titer
☐ Flu Vaccine	☐ DOT Physical	☐ Mumps Titer

EMPLOYERS WITH AN ACTIVE ACCOUNT - SELECT ALL AUTHORIZED SERVICES

☐ Fire Fighter Physical	☐ Audio Screening (Pure Tone)	☐ Hepatitis B Vaccine (2 dose)
☐ Police Physical	☐ Audio Screening (OSHA Booth)	☐ TDAP Vaccine
☐ Dive Physical	☐ Visual Acuity Screen	☐ Other*: _____
☐ Hazardous Material Physical	☐ Ishihara Color Test	☐ Other: _____
☐ Respirator Physical	☐ Electrocardiogram (EKG)	☐ Other: _____
☐ Respirator Physical w/ Questionnaire	☐ Chest x-ray (2 View)	*Other services must be on your Account Setup Form*
☐ Respirator Fit Test (Qualitative)	☐ Spirometry (PFT)	

REASON FOR VISIT	**SPECIAL INSTRUCTIONS**
☐ Post Accident	
☐ Pre-Employment	
☐ Reasonable Suspicion	

REQUIRED FOR ALL WORKERS' COMPENSATION VISITS

☐ Workers' Compensation Injury Treatment Date of Injury: _____ Type of Injury: _____

Where are claims to be filed? ☐ Bill Employer ☐ Insurance Carrier — W/C Carrier Name: _____

W/C Carrier Address: _____

W/C Carrier Phone: _____ W/C Carrier Fax: _____ Policy Number: _____

BILLING INFORMATION

☐ Established Employer Account *(account must be current - no past due balance)*

☐ Non-Established Employer Account *(Submit payment via **employers.doctorscare.com/pay** - select the 'Non-Established Employer Payment' option. Printed payment receipt must be presented to the front desk staff at time of service.)*

EMPLOYER AUTHORIZATION

This certifies that the above information is correct. I authorize the medical provider to provide medical treatment to the employee named above. I also understand that the services provided will be paid in full by the company listed above and authorized by my signature below.

X _____

Employer Signature (REQUIRED) **Printed Name (REQUIRED)** Title Date

PSR NAME: _____ CLINICAL STAFF NAME: _____ LOCATION: _____

Occ Med Billing Hotline - Call Extension 5007703 or 803-724-5860 • Occ Med Service Support - Call 888-845-6887

To create an account, contact us at: **https://employers.doctorscare.com**