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**		

AUTHORIZED SERVICES (Check all that apply) *** Employee must bring this completed form for services to be rendered***

☐ In-house Drug Screen - # Panels: _____	☐ Visual Acuity Test	☐ PPD (Reading)
☐ 5 Panel External DOT Drug Screen	☐ Color Vision Exam	☐ PPD/TB Q Gold/Blood
☐ Urine Collection	☐ Spirometry/Breathing Capacity test	☐ Varicella-Zoster
☐ Breath Alcohol Test	☐ Chest X-ray 2 View	☐ Rubella Antibody
☐ DOT Physical	☐ Flu Vaccine	☐ Mumps Antibody
☐ General Physical	☐ Tdap Vaccine	☐ Rubeola Antibody
☐ Respirator Physical	☐ Blood Lead Level	☐ Respirator Fit Test (N95 only)
☐ EKG	☐ Hepatitis B Vaccine	☐ Other: _____
☐ Pure Tone Audiometry	☐ Hepatitis B Titer	
☐ OSHA Audio Exam	☐ PPD (TB Skin Test)	

REASON FOR VISIT

☐ Post Accident ☐ Pre-Employment ☐ Reasonable Suspicion	**SPECIAL INSTRUCTIONS**

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 **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

https://employers.doctorscare.com