OccMed Billing Hotline - Call Extension 5007703 or 803-724-5860

Employer Authorization Form

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

Date: _____ Patient Name: _____

Employer: _____ Phone: _____ Fax: _____

Employer Address: _____

Primary Contact: _____ Email: _____

REQUIRED SERVICES (check all that apply)

***** Employee must bring this completed form for services to be rendered*****

- ☐ Hair 5 Panel Drug Screen, non-DOT (80300.H)
- ☐ Hair Collection Only (99000.H)
- ☐ 5 Panel In-house Drug Screen non-DOT (80300.5I)
- ☐ 10 Panel In-house Drug Screen non-DOT (80300.10I)
- ☐ 5 Panel External Lab **DOT** Drug Screen (80300.D)
- ☐ 5 Panel External Lab Drug Screen, non-DOT (80300.5L)
- ☐ 10 Panel External Lab Drug Screen, non-DOT (80300.10L)
- ☐ Urine Collection Only, **DOT** (99000.D)
- ☐ Urine Collection Only, non-DOT (99000.N)
- ☐ Breath Alcohol Test **DOT** (82075.D)
- ☐ Breath Alcohol Test non-DOT (82075.N)
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

- ☐ DOT Physical (99385.D)
- ☐ General Physical (99385.G)
- ☐ Pre-Employment Physical (99385.P)
- ☐ Respiratory Clearance Physical (99385.R)
- ☐ History Review W/O Exam (99385.P0010)
- ☐ Fit for Duty Physical (99385.F)
- ☐ Hazmat Physical (99385.H)
- ☐ EKG (93000)
- ☐ Pure Tone Audiometry (92552)
- ☐ OSHA Audio Exam (92552.O)
- ☐ Visual Acuity Test (99173)
- ☐ Color Vision Exam (92283)
- ☐ Hep A Vaccine (90632)
- ☐ Spirometry/Breathing Capacity Test (94010)
- ☐ Chest X-ray 1 View (71010)
- ☐ Chest X-ray 2 View (71020)
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

- ☐ Flu Vaccine (90658)
- ☐ Blood Lead Level (83655)
- ☐ Hep B Vaccine (90746)
- ☐ Hepatitus B Titer (86706)
- ☐ Tetanus,Diptheria (90714)
- ☐ Tetanus, (Tdap) (90715)
- ☐ PPD (TB Test) (86580)
- ☐ PPD/TB Q Gold/Blood (86480.PPD)
- ☐ MMR Vaccine (90707)
- ☐ Varicella-Zoster (86787)
- ☐ Rubella Antibody (86762)
- ☐ Mumps Antibody (86735)
- ☐ Rubeola Antibody (86765)
- ☐ Respirator Fit Test (99078.R)
- ☐ Respirator Questionnaire (99078.Q)

Special Instructions: _____

ALL DRUG SCREENS & BREATH ALCOHOL TESTS (Please Choose One): ☐ **Return to Duty** ☐ **Follow-Up** ☐ **Cause/Suspicion** ☐ **Pre-Employment** ☐ **Workers Comp** ☐ **Random** ☐ **Post Injury** ☐ **Post Accident**

REQUIRED FOR ALL WORKERS' COMPENSATION VISITS

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

☐ Post Accident Drug Screen Required → *Check Type Above* Has employer filled out First Report of Injury? ☐ Yes (send copy) ☐ No

☐ Post Accident DOT Drug Screen Required → *Check Type Above* Breath Alcohol Testing ☐ DOT (82075.D) or ☐ Non-DOT (82075.N)

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 INSTRUCTIONS

☐ Bill Patient - Payment due at time of service ***(PSR use Fee For Service Account BT377)***

☐ Bill Credit Card on File

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

☐ Bill New Credit Card Name on Card: _____ Card Number: _____ Exp Date: _____ Code: _____

Card Address: _____ City: _____ State: _____ Zip Code: _____

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

EMPLOYER 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 _____ _____ _____ Title: _____

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

EMPLOYEE SIGNATURE & STATEMENT

I understand that I will be responsible for payment of services indicated above should circumstances arise resulting in non-payment from my employer.

X _____ _____

Employee Signature (REQUIRED) Date

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

Visit **https://employers.doctorscare.com** for the latest updated form