



Customer Service Agreement

Doctors Care – Employer Health Services

1818 Henderson Street | Columbia, SC 29201

Phone: 843.238.4520 | Email: sales@doctorscare.com

SECTION I: COMPANY INFORMATION

Today's Date		TPA Name	
Company Name			
Number of Employees		Health Insurance Carrier	
Phone		Fax	
Main Company Address City, State, ZIP Code			

COMPANY INFORMATION

1. Primary Contact/DER Name	2. Secondary Contact
Title/Role	Title/Role
Address City, State, ZIP Code	Address City, State, ZIP Code
Phone	Phone
Fax	Fax
Email	Email

BILLING INFORMATION

Primary Billing*

Billing Address City, State, ZIP Code	
Contact Name and Title	
Phone	
Fax	
Email	<input type="checkbox"/> Email Invoices (Secure)

Workers' Comp Billing

Carrier Name	
Billing Address	
Phone	
Fax	
Are workers' comp claims to be billed to carrier or to your company?	<input type="checkbox"/> Bill Carrier <input type="checkbox"/> Bill Primary Billing Address

*Provide alternate billing addresses on page 3

SECTION II:**REQUIRED SERVICES AND REPORTING**

<input type="checkbox"/> Hair 5 Panel Drug Screen, non-DOT (80300.H)	<input type="checkbox"/> Respiratory Clearance Physical (99385.R)	<input type="checkbox"/> Blood Lead Level (83655)
<input type="checkbox"/> Hair Collection Only (99000.H)	<input type="checkbox"/> History Review W/O Exam (99385.P0010)	<input type="checkbox"/> Hep B Vaccine (90746)
<input type="checkbox"/> 5 Panel In-house Drug Screen non-DOT (80300.5I)	<input type="checkbox"/> Fit for Duty Physical (99385.F)	<input type="checkbox"/> Hepatitis B Titer (86706)
<input type="checkbox"/> 10 Panel In-house Drug Screen non-DOT (80300.10I)	<input type="checkbox"/> Hazmat Physical (99385.H)	<input type="checkbox"/> Tetanus,Diphtheria (90714)
<input type="checkbox"/> 5 Panel External Lab DOT Drug Screen (80300.D)	<input type="checkbox"/> EKG (93000)	<input type="checkbox"/> Tetanus, (Tdap) (90715)
<input type="checkbox"/> 5 Panel External Lab Drug Screen, non-DOT (80300.5L)	<input type="checkbox"/> Pure Tone Audiometry (92552)	<input type="checkbox"/> PPD (TB Test) (86580)
<input type="checkbox"/> 10 Panel External Lab Drug Screen, non-DOT (80300.10L)	<input type="checkbox"/> OSHA Audio Exam (92552.O)	<input type="checkbox"/> PPD/TB Q Gold/Blood (86480.PPD)
<input type="checkbox"/> Urine Collection Only, DOT (99000.D)	<input type="checkbox"/> Visual Acuity Test (99173)	<input type="checkbox"/> MMR Vaccine (90707)
<input type="checkbox"/> Urine Collection Only, non-DOT (99000.N)	<input type="checkbox"/> Color Vision Exam (92283)	<input type="checkbox"/> Varicella-Zoster (86787)
<input type="checkbox"/> Breath Alcohol Test DOT (82075.D)	<input type="checkbox"/> Hep A Vaccine (90632)	<input type="checkbox"/> Rubella Antibody (86762)
<input type="checkbox"/> Breath Alcohol Test non-DOT (82075.N)	<input type="checkbox"/> Spirometry/Breathing Capacity Test (94010)	<input type="checkbox"/> Mumps Antibody (86735)
<input type="checkbox"/> DOT Physical (99385.D)	<input type="checkbox"/> Chest X-ray 1 View (71010)	<input type="checkbox"/> Rubeola Antibody (86765)
<input type="checkbox"/> General Physical (99385.G)	<input type="checkbox"/> Chest X-ray 2 View (71020)	<input type="checkbox"/> Respirator Fit Test (99078.R)
<input type="checkbox"/> Pre-Employment Physical (99385.P)	<input type="checkbox"/> Flu Vaccine (90658)	<input type="checkbox"/> Respirator Questionnaire (99078.Q)
<input type="checkbox"/> Other: _____		

WELLNESS SERVICES Biometric Screening**ONSITE TRAINING SERVICES** Diabetes Sleep Disorders Heart Healthy Tobacco Cessation Men and Women's Health Nutrition Weight Control Bloodborne OSHA Training Services Stress Relief Back Care***EMPLOYEE MUST BRING IN COMPLETED AUTHORIZATION FORM FOR SERVICES TO BE PERFORMED****WORKERS' COMPENSATION**

Indicate where the Return to Work Status report is to be sent:

 Workers' Compensation Injury Treatment Post-Accident Drug Screen Required DOT Non-DOT (5, 7, 9, or 10 Panel) _____**Please indicate where and how breath alcohol tests and physical results are to be reported:** Email Fax Return with Employee Mail**Please list specific protocol instructions***

*Doctors Care will report results and applicable information as specified above

SECTION III:**BILLING AND PAYMENT INFORMATION****OPTION A:** **Recurring Payment (requires credit card)**

Pay via Visa, MasterCard, Discover Card or American Express with receipt emailed to the billing contact on file. Invoices are mailed on the 2nd business day of the month and are due on the 20th. Payments for accounts with a credit card on file will be processed after the 20th of each month. Any billing discrepancies must be brought to our attention prior to the 20th so we may make the necessary corrections before processing your credit card payment. Past due accounts will be assessed a late payment fee of 15%. Accounts with past due balances over 60 days old will be terminated and referred to a collection agency for payment.

OPTION B: **Balance Billing (requires approval and credit card* for balance billing)**

A monthly invoice of open charges will be sent to you at the billing address on file. Customer agrees to pay the invoice on the 20th of each month. If payment falls more than 60 days in arrears, your account will be inactivated and referred to a collection agency for payment and services must be paid for at the time they are rendered. Past due balances will incur a late payment fee of 15% of the outstanding balance.

*Credit card will not be billed unless payment is not made within 30 days.

I, _____, authorize Doctors Care (c/o UCI Medical Affiliates) to charge my account for balance due for payment of my account with Doctors Care.

CREDIT CARD INFORMATION

Type of Card	<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> American Express
Cardholder Name*	
Account Number	
Expiration Date	
Billing Zip Code	

*The name MUST match the name on the credit card listed

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify UCI Medical Affiliates in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day.

Credit Card Authorization Signature: _____

All accounts may pay online by echeck by visiting <https://doctorscare.com/pay/>.

If you have some services that must be billed to an alternate billing address, please provide that information below:

Name	
Address	
Phone	
Services to be billed to this address	

Please list the Doctors Care facility/facilities that your company would like to use:

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SECTION IV:**SERVICES BILLED TO TPA**

- | | | |
|---|---|---|
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| <input type="checkbox"/> Other: _____ | | |

SECTION V:**FEES & NOTES**

This section to be completed by business development representative

SECTION VI:

CUSTOMER ACKNOWLEDGEMENT

Employer Authorized Name

Title

X

Employer Authorized Signature

Date

This agreement will be in effect until either party gives written notice of change of service, terms or termination.