Employer Health Services Agreement

Doctors Care – Employer Health Services
1818 Henderson Street | Columbia, SC 29201
Phone: 843.238.4520 | Email: **sales@doctorscare.com**

Today's Date

Client Rep

SECTION I: COMPANY INFORMATION			
Company Name			
TPA Name			
Number of Employees		Health Insurance Carrier	
Phone		Fax	
Main Company Address City, State, ZIP Code			

CONTACT 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	

EMPLOYER SERVICE BILLING INFORMATION	
Primary Billing Address*	
Billing Address City, State, ZIP Code	
Contact Name and Title	
Phone	
Fax	
Email	☐ Email Invoices (Secure)
Workers' Comp Billing Address	
Carrier Name	
Billing Address	
Phone	
Fax	
Are workers' comp claims to be billed to carrier or to your company?	☐ Bill Carrier ☐ Bill Primary Billing Address

*Provide alternate billing addresses on page 3

SECTION II: AUTHORIZED SERVICES AND PRICING

- ☐ 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)
- ☐ DOT Physical (99385.D)
- ☐ General Physical (99385.G)
- ☐ Pre-Employment Physical (99385.P)
- ☐ Wellness Services (Req. Wellness Svc. Agreement)
- ☐ 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)
- ☐ Flu Vaccine (90658)
- ☐ Other: _____
- ☐ Blood Lead Level (83655)
- ☐ Hep B Vaccine (90739/90746)
- ☐ 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)

Please indicate where and how breath alcohol tests and physical results are to be reported:

☐ Email ☐ Return with employee ☐ After hours phone number for positive results

WORKERS' COMPENSATION	
☐ Workers' Compensation Injury Treatment	Indicate where the Return to Work Status report is to be emailed:
☐ Post-Accident Drug Screen Required ☐ Post-Accident Breath Alcohol Required	☐ DOT ☐ Non-DOT (5, 7, 9, or 10 Panel) _____

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	☐ Visa ☐ MasterCard ☐ Discover ☐ 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 — 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:

SECTION IV: SERVICES BILLED TO TPA

TPA must provide billing information before any services will be performed.

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- ☐ Respirator Questionnaire (99078.Q)
- ☐ Other: _____

SECTION V: FEES & SPECIAL INSTRUCTIONS

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.