



Occupational Medicine/WKC Authorization Form (for Employer)

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

Date: _____ Patient Name: _____

Employer: _____ Phone: _____ Fax: _____

Employer Address: _____

Primary Contact: _____ Email: _____

AUTHORIZED SERVICES (check all that apply)

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Hair 5 Panel Drug Screen, non-DOT (80300.H) | <input type="checkbox"/> Fit for Duty Physical (99385.F) | <input type="checkbox"/> Tetanus, (Tdap) (90715) |
| <input type="checkbox"/> Hair Collection Only (99000.H) | <input type="checkbox"/> Hazmat Physical (99385.H) | <input type="checkbox"/> PPD (TB Test) (86580) |
| <input type="checkbox"/> 5 Panel In-house Drug Screen non-DOT (80300.5I) | <input type="checkbox"/> EKG (93000) | <input type="checkbox"/> PPD/TB Q Gold/Blood (86480.PPD) |
| <input type="checkbox"/> 10 Panel In-house Drug Screen non-DOT (80300.10I) | <input type="checkbox"/> Pure Tone Audiometry (92552) | <input type="checkbox"/> MMR Vaccine (90707) |
| <input type="checkbox"/> 5 Panel External Lab DOT Drug Screen (80300.D) | <input type="checkbox"/> OSHA Audio Exam (92552.O) | <input type="checkbox"/> Varicella-Zoster (86787) |
| <input type="checkbox"/> 5 Panel External Lab Drug Screen, non-DOT (80300.5L) | <input type="checkbox"/> Visual Acuity Test (99173) | <input type="checkbox"/> Rubella Antibody (86762) |
| <input type="checkbox"/> 10 Panel External Lab Drug Screen, non-DOT (80300.10L) | <input type="checkbox"/> Color Vision Exam (92283) | <input type="checkbox"/> Mumps Antibody (86735) |
| <input type="checkbox"/> Urine Collection Only, DOT (99000.D) | <input type="checkbox"/> Hep A Vaccine (90632) | <input type="checkbox"/> Rubeola Antibody (86765) |
| <input type="checkbox"/> Urine Collection Only, non-DOT (99000.N) | <input type="checkbox"/> Spirometry/Breathing Capacity Test (94010) | <input type="checkbox"/> Respirator Fit Test (99078.R) |
| <input type="checkbox"/> Breath Alcohol Test DOT (82075.D) | <input type="checkbox"/> Chest X-ray 1 View (71010) | <input type="checkbox"/> Respirator Questionnaire (99078.Q) |
| <input type="checkbox"/> Breath Alcohol Test non-DOT (82075.N) | <input type="checkbox"/> Chest X-ray 2 View (71020) | <input type="checkbox"/> COVID-19 Diagnostic Test (87635) |
| <input type="checkbox"/> DOT Physical (99385.D) | <input type="checkbox"/> Flu Vaccine (90674) | <input type="checkbox"/> Provider Virtual Visit (99421) |
| <input type="checkbox"/> General Physical (99385.G) | <input type="checkbox"/> Blood Lead Level (83655) | <input type="checkbox"/> Specimen Collection (99000.c) |
| <input type="checkbox"/> Pre-Employment Physical (99385.P) | <input type="checkbox"/> Hep B Vaccine (90739/90746) | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Respiratory Clearance Physical (99385.R) | <input type="checkbox"/> Hepatitis B Titer (86706) | <input type="checkbox"/> _____ |
| <input type="checkbox"/> History Review W/O Exam (99385.P0010) | <input type="checkbox"/> Tetanus,Diptheria (90714) | <input type="checkbox"/> _____ |

REASON FOR VISIT	SPECIAL INSTRUCTIONS
<input type="checkbox"/> Post Accident <input type="checkbox"/> Pre-Employment <input type="checkbox"/> Reasonable Suspicion	

REQUIRED FOR ALL WORKERS' COMPENSATION VISITS	
<input type="checkbox"/> Workers' Compensation Injury Treatment	Date of Injury: _____ Type of Injury: _____
Where are claims to be filed? <input type="checkbox"/> Bill Employer <input type="checkbox"/> Insurance Carrier	W/C Carrier Name: _____
W/C Carrier Address: _____	
W/C Carrier Phone: _____	W/C Carrier Fax: _____ Policy Number: _____

BILLING INFORMATION
<input type="checkbox"/> Established Employer Account (account must be current - no past due balance)
<input type="checkbox"/> 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 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				
<table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">Employer Signature (REQUIRED)</td> <td style="width: 30%;">Printed Name (REQUIRED)</td> <td style="width: 20%;">Title</td> <td style="width: 20%;">Date</td> </tr> </table>	Employer Signature (REQUIRED)	Printed Name (REQUIRED)	Title	Date
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
Visit <https://employers.doctorscare.com> for the most current forms.