Occ Med 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 ******

- ☐ 5 Panel Instant Drug Screen e-Cup (80300.I)
- ☐ Hair 5 Panel Drug Screen, Non-NIDA (80300.H)
- ☐ DOT 5 Panel NIDA Drug Screen (80300.D)
- ☐ 5 Panel Lab Drug Screen, Non-NIDA (80300.N)
- ☐ 7 Panel Drug Screen, Non-NIDA (80300.N)
- ☐ 9 Panel Drug Screen, Non-NIDA (80300.N)
- ☐ 10 Panel Drug Screen, Non-NIDA (80300.N)
- ☐ 10 Panel Instant Drug Screen M-Cup (80300.M)
- ☐ Collection Only, DOT - Urine, NIDA (99000.D)
- ☐ Collection Only, Urine, Non-NIDA (99000.N)
- ☐ Hair Collection Only (99000.H)
- ☐ DOT Breath Alcohol Testing (82075.D)
- ☐ Non-DOT Breath Alcohol Testing (82075.N)
- ☐ Chest X-Ray - 1 View (71010)
- ☐ Chest X-Ray - 2 View (71020)
- ☐ 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)
- ☐ Breathing Capacity Test-Spirometry (94010)
- ☐ 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)
- ☐ MMR Vaccine (90707)
- ☐ Varicella-Zoster (86787)
- ☐ Rubella Antibody (86762)
- ☐ Mumps Antibody (86735)
- ☐ Rubeola Antibody (86765)
- ☐ Other _____
- ☐ Other _____

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 CLAIMS

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

☐ Post Accident Drug Screen Required (80300.N) Has employer filled out First Report of Injury? ☐ Yes (send copy) ☐ No

☐ Post Accident DOT Drug Screen Required (80300.D) Breath Alcohol Testing ☐ DOT (82075.D) or ☐ Non-DOT (82075.N)

Where are claims to be filed? ☐ 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.*

_____ _____

Employer Signature (REQUIRED) Date

_____ _____

Printed Name (REQUIRED) Title

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.

_____ _____

Employee Signature (REQUIRED) Date

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