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***

- ☐ 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)
- ☐ 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 (90674)
- ☐ 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)
- ☐ Varicella-Zoster (86787)
- ☐ Rubella Antibody (86762)
- ☐ Mumps Antibody (86735)
- ☐ Rubeola Antibody (86765)
- ☐ Respirator Fit Test (99078.R)
- ☐ Respirator Questionnaire (99078.Q)
- ☐ COVID-19 Diagnostic Test (87635)
- ☐ Provider Virtual Visit (99421)
- ☐ Specimen Collection (99000.c)
- ☐ _____
- ☐ _____
- ☐ _____

REASON FOR VISIT	**SPECIAL INSTRUCTIONS**
☐ Post Accident ☐ Pre-Employment ☐ Reasonable Suspicion	

REQUIRED FOR ALL WORKERS' COMPENSATION VISITS

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

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 INFORMATION

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

☐ 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 _____

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.