Atlantic Health Urgent Care

Employer Request & Authorization

(Information must be provided by a Designated Employer Representative (DER) or their C/TPA per 49 CFR 40.)

EMPLOYEE MUST BRING VALID IDENTIFICATION FOR ALL SERVICES

EMPLOYEE DATA

EMPLOYEE NAME _____ DATE OF BIRTH _____

COMPANY NAME _____

COMPANY ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

WORK INJURY

INSURANCE *(if applicable)* _____ POLICY # _____ WORK COMP CLAIM # _____

INSURANCE ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____ DESCRIPTION OF INJURY _____

DRUG & ALCOHOL TESTING

Urine Drug Screen
Check one:

- ☐ INSTACUP
- ☐ INCLUDE THC DRUG PANEL
- ☐ LAB URINALYSIS/MRO 10-PANEL
- ☐ BREATH ALCOHOL
- ☐ K2 SCREENING

Type of Drug Testing
Check one:

- ☐ PRE-EMPLOYMENT
- ☐ POST-ACCIDENT
- ☐ REASONABLE SUSPICION
- ☐ RANDOM
- ☐ OTHER _____

EXAMINATIONS

PHYSICAL EXAMINATION

- ☐ PRE-EMPLOYMENT PHYSICAL
- ☐ RETURN TO WORK
- ☐ COMPREHENSIVE EXAM
- ☐ D.O.T. EXAM
- ☐ INCLUDE PPD IMPLANT/READING

SPECIAL EXAMINATION

- ☐ OSHA RESPIRATORY EXAM — REVIEW OSHA QUESTIONNAIRE
- ☐ VISION TEST
- ☐ EKG
- ☐ PULMONARY FUNCTION TEST — SPIROMETRY
- ☐ OTHER _____

X-RAY

- ☐ CHEST ☐ 1 VIEW ☐ 2 VIEW ☐ OTHER _____

VACCINATIONS

- ☐ FLU ☐ HEP A* ☐ HEP B* ☐ MMR*
- ☐ TDAP ☐ TETANUS ☐ VARICELLA*

*requires advance notice

COVID-19

- ☐ RT-PCR (LAB)
- ☐ RAPID ANTIGEN
- ☐ ANTIBODY BLOOD TEST (LAB)

LABORATORY

- ☐ HEP B TITER
- ☐ MMR TITER
- ☐ RUBEOLA TITER
- ☐ VARICELLA TITER
- ☐ QUANTIFERON (TB GOLD)

OTHER SERVICES REQUESTED _____

BILLING

- ☐ BILL TO WORKERS COMPENSATION INSURANCE
- ☐ DIRECT BILL TO EMPLOYER
- ☐ EMPLOYEE TO PAY CHARGES

We are authorizing Immediate Care to provide services to our employees. By doing so, we acknowledge that, if the claim is denied by the workers compensation insurance carrier/TPA, we will notify Immediate Care of the denial and will be responsible for the payment of all services.

SIGNATURE OF PERSON AUTHORIZING SERVICES _____ DATE _____

PRINT NAME OF PERSON AUTHORIZING SERVICES _____