COASTAL URGENT CARE

Occupational Medicine: New Company Information Form

Company Information:

Company Name:

Address: Address:

City: State: Zip:

Phone: Fax: Service Industry?

Billing Information:

Billing Contact:

Address: Address:

City: State: Zip:

Phone: Fax: ACH Payment? ☐ Yes ☐ No

Email Invoices? ☐ Yes ☐ No Email for Invoice:

Account Services:

Main Contact for Service Related Questions:

Office Phone: Cell Phone: Email:

Second Contact:

Office Phone: Cell Phone: Email:

Safety/Injury Contact:

Office Phone: Cell Phone: Email:

Services Needed:

Physicals:

☐ DOT-CDL ☐ DOT-USCG ☐ Non-DOT Routine ☐ UKOOA/OGUK ☐ Crane Operator ☐ Hazmat ☐ Return to Duty

Screenings:

☐ DOT DS (SouthStar as MRO) ☐ Non-DOT DS (SouthStar as MRO) ☐ Quick Screens

☐ DS Collection Only (Company has own CCF) LAB:

☐ DOT Breath Alcohol ☐ Non-DOT Breath Alcohol ☐ (company has own form)

OCC Med Services:

☐ 3-View Back X-Ray ☐ 5-View Back X-Ray ☐ 2-View Chest X-Ray ☐ 1-View Chest X-Ray ☐ Lift Capacity Evaluation

☐ Audio ☐ Pulmonary Function Test ☐ Respirator Fit Test Model:

☐ Full Face ☐ Half Face Other:

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Results:

How would you like results send to you? ☐ Fax ☐ Email

If Fax: Fax Recipient: _____ Fax #: _____

If Email: Email Address: _____

Password: _____ 6 or LESS Characters

Authorization:

Does your company have their own Authorization? ☐ Yes ☐ No

How will you send in the Authorization? ☐ Fax ☐ Email ☐ With Employee

Third Party Administrator (TPA):

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

What services will be billed to this TPA?: _____

_____

Worker's Comp. Information:

Company Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____