



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: