



Employer Billing Protocol and Instructions

Company Medical Records to be sent via: **Secured Fax (Private)** **Email (encrypted only)** **Health Data Web Portal**

Completed by: _____

Job Title: _____

Date: _____

EMPLOYER INFORMATION

Business Name: _____

Primary Contact Name/Title: _____

Business Address: _____

Work#: _____ Cell Ph#: _____

Business Ph#: _____

Email: _____

***Secure Fax:**

Secondary Contact Name/Title: _____

Designated Employer Rep (DER): _____

Work#: _____ Cell Ph#: _____

DER Ph#: _____

Email: _____

AUTHORIZED SERVICES TO BE PROVIDED/WORKERS' COMP PROTOCOL INSTRUCTIONS

PHYSICALS	DRUG SCREEN	DRUG AND ALCOHOL		OTHER SERVICES
		DOT	NON-DOT	
		<i>Please Select Chain of Custody:</i>		
		Employer CCF	Clinic CCF ePassport Other: Specify _____	

IMMUNIZATION SERVICES AND LABORATORY TESTING

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COMPANY BILLING INFORMATION

Billing Address: _____

Billing Contact: _____ Phone: _____ Email: _____

WORKERS' COMPENSATION BILLING INFORMATION

Workers' Comp Insurance Name: _____

Claims Address: _____

Contact Name/Adjuster: _____ Phone: _____ Fax: _____

Policy #: _____ Exp. Date: _____ Email: _____



MEDICAL CASE PROTOCOL INSTRUCTIONS

Business Name: _____

588-HCB5@G9FJ-79G

1. Explain any additional services that your workers need for a Workers' Comp injury (i.e. Drug Screen, Breath Alcohol Test, etc.):

2. Does your company offer Light Duty for your employees? If so, please specify Return to Work instructions:

4. Please provide Pharmacy name and phone number for your employees in the event medications are prescribed.

5. Do you have your own forms (*CCF, RTW, Physical, Lab Requisition, etc.*)? If so, please attach a copy for our records and specify lab.

6. Other available services: (*Labs, Flu Clinic, On-site (Random/Pre-Employment) Drug Testing*)

BILLING AND PAYMENT INFORMATION (Complete all 3 Questions)

1. Please describe when you would like us to bill you directly. Specify a billing contact.

2. Please describe when Workers' Compensation is billed:

3. Please describe when an employee is to pay at time of service (*i.e. Flu shots*):

THIRD PARTY ADMINISTRATOR (TPA) (if applicable)

Name: _____ Phone: _____

Address: _____

Fax: _____ Email: _____

Signature

Date/Time