AFC URGENT CARE RALEIGH MIDTOWN
2913 WAKE FOREST ROAD
RALEIGH, NC 27609
P: 919-899-4000
F: 984-200-5343

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

____Return to Work
____Pre-Employment Physical
____Annual Physical
____DOT Physical
____DOT Recertification
____Fit for Duty

DRUG SCREEN

____Random
____Pre-Employment
____Return to Work
____Follow-Up
____Reasonable Suspicion
____Periodic Review
____Post Accident

DRUG AND ALCOHOL

Please Select Chain of Custody:
☐ Employer CCF ☐ Clinic CCF ☐ ePassport ☐ Other: Specify_____

DOT	NON-DOT
____Breath Alcohol	____Breath Alcohol
____Urine Drug Screen	____In-House Rapid (5 Panel)
____Other: _____	____In-House Rapid (10 Panel)
	____Collection Only
	____Hair Drug Screen
	____Other1:_____

OTHER SERVICES

____Spirometry
____Audiometry (Hearing Test)
____Snellen (Vision Exam)
____Ishihara (Color Blind Test)
____OSHA Respirator Questionnaire
____Respirator Fit Test
____Chest X-Ray
____EKG

IMMUNIZATION SERVICES AND LABORATORY TESTING

____PPD/Tuberculosis Skin Test - 1 - Step	____Vaccine - Influenza	____CBC	____ Post Exposure
____PPD/Tuberculosis Skin Test - 2 - Step	____Vaccine - Pneumonia	____CMP	Other Lab Services - Specify Below
____Vaccine - Hep A: ___ 1st ___2nd (180 days)	Other Vaccines - Specify Below	____Urinalysis	_____
____Vaccine-Hep B:___1st___2nd(30 days)___3rd(180 days)	_____	____Titer - Hepatitis A	_____
____Tetanus: ____TD ____Tdap	_____	____Titer - Hepatitis B	_____

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: _____

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MEDICAL CASE PROTOCOL INSTRUCTIONS

Business Name: _____

ADDITIONAL SERVICES

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 _____