Company Protocol

Company Name: _____

(PLEASE PRINT)

Type of Industry: _____# of employees _____Website: _____

Parent Company:_____ Main Office Phone: _____

Address: _____City_____State_____Zip_____

Local Address_ _____City_____State_____Zip_____

Local Contact Name:_____ Phone: _____Email: _____

Fax: _____ Is fax line secure? YES NO

Company Primary Contact:_____ Position_____

Phone:_____Fax:_____E-mail_____

First Alternate Contact:_____Position_____

Phone:_____Fax:_____E-mail_____

Second Alternate Contact:_____Position_____

Phone:_____Fax:_____E-mail_____

Third Alternate Contact:_____Position_____

Phone:_____Fax:_____E-mail_____

HELP US DO IT YOUR WAY!! SEND AUTHORIZATION FORMS WITH EACH EMPLOYEE FOR BEST RESULTS
Circle or check request:

Do you have your own forms? Yes, Please use them_____ No, Use yours____

How do you want to receive drug screens? **___ FAX (list #_____)** **___ EMAIL** **___ Mail**
_____We will send to Primary contact unless list someone else here:
Name: **Fax# or Email:**
Phone:
Address:

What results do you want from physicals? **ALL ____** **CLEARANCE ONLY_____**

What results do you want from tests performed (other than drug screens)? **ALL_____** **CLEARANCE ONLY_____**

How do you want to receive Physical exam or test reports? **___ FAX (list #_____)** **___ EMAIL** **___ Mail**
___We will send to Primary contact unless list someone else here:
Name: **Fax# or Email:**
Phone:
Address:

How do you want to get your work status reports? **___ FAX (list #_____)** **___ EMAIL** **___ Mail**
___We will send to Primary contact unless list someone else here:
Name: **Fax# or Email:**
Phone:
Address:

**** We will mail required originals and all information you request each Friday.***

By signing this protocol you agree to pay in full all requested services whether approved by insurance carrier or not.

Company Representative Signature: _____Date: _____

Print Name: _____**Title:**_____

This form will be updated every two years from date received. It is your responsibility to notify us of any changes that occur asap.

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Company Name: _____

(PLEASE PRINT)

DRUG SCREEN INFO:

Do you use a third party or a specific lab for your physicals &/or drug screens? Yes_____ No_____

Will you send employee with chain of custody and kit? Yes___ No___

Third Party Administrator/Consortium Name: _____Point of contact: _____

Phone: _____Fax_ _____E-mail _____

Specific Lab Used: Name: _____Point of contact: _____

Phone: _____Fax_ _____E-mail _____

Do you want your WC injuries to have drug screens on 1st visit? Yes__ No __ _

For WC drug screens, will we bill your company directly or bill the insurance carrier? Bill us _____Bill Carrier____
(*if carrier does not pay we will charge a re-billing fee to bill you)

Will we send all non negative UDS for confirmation? Yes___ No ___ Call me First____(we will hold for 24 hours only)

_____We will call Primary contact unless list someone else here:
Name: **Fax# or Email:**
Phone:
Alternate Phone:
Address:

BILLING (net 30 and/or MS workers comp fee schedule)

Physicals/Tests Contact_____Email_____
Address_____City_____State_____Zip_____
Phone:_____ Fax_____

Drug Screens Contact_____Email_____
Address_____City_____State_____Zip_____
Phone:_____ Fax_____

Worker's Injury Care Company_____Contact_____
Address_____City_____State_____Zip_____
Phone:_____ Fax_____

(If deemed Non Work Related full payment required from company—we do not bill employees insurance if you request service)

Any Other Special Instructions List here:

_____

_____

By signing this protocol you agree to pay in full all requested services whether approved by insurance carrier or not.

Company Representative Signature: _____Date: _____

Print Name: _____**Title:**_____

This form will be updated every two years from date received. It is your responsibility to notify us of any changes that occur asap.