

INDUSTRIAL ACCOUNT PROFILE

DATE _____

DER (Employer)	TPA (Third Party Administrator)
Name _____	Name _____
Mailing Address _____	Mailing Address _____
Physical Address _____	_____
Contact Person _____	Contact Person _____
Phone # _____	Phone # _____
Fax # _____	Fax # _____

SERVICES (check services requested)

INDUSTRIAL SERVICES

EMPLOYMENT PHYSICALS

DOT PE

Pre-employment

Special form Yes No

Lab (please specify)

Complete Blood Count (CBC)

Urinalysis

Urinalysis **DIPSTICK - DOT PE**

Chemistry Panel _____

X-RAY (please specify)

Chest X-Ray

Lumbosacral spine X-Ray

MISC (please specify)

EKG

Pulmonary Function Test

Audiogram

OTHER (please list) _____

DRUG & ALCOHOL SERVICES

Drug Screen:

Collection only

MRO/Provider Interpretation

Federal (DOT) (5 panel)

Forensic (Non-DOT) (10 panel)

Lab _____

Medical Center's MRO

Outside MRO

Name _____

Address _____

Phone # _____

Fax # _____

MRO _____

BAT testing (Breath Alcohol Testing)

Federal (DOT) Forensic (Non-DOT)

Dr: _____

SPECIAL INSTRUCTIONS:

PATIENT TO BRING WITH THEM:

- CCF (*Custody & Control Form or Chain of Custody*) only not our MRO (Lab is Quest and we'll use our kit)
- CCF (*Custody & Control Form or Chain of Custody*) and collection kit w/shipping supplies (not our MRO, not Quest lab)
- Nothing (our MRO, Quest Lab)

ADVISED CALLER:

- We do not store supplies
- Collection hours: Laboratory at Central Location
 Drug 9:30 a.m. - 11 a.m. & 1:30 p.m. - 3 p.m. BAT 9:30 a.m. - 11 a.m. & 1:30 p.m. - 4:30 p.m.
- Appointment required
- If required items not brought in by employee, test may be rescheduled due to not having necessary items.

BILLING INFORMATION:

- | | | | |
|----------------------|-----------------------------------|---|-------------------------------------|
| Bill Collection to: | <input type="checkbox"/> Employer | <input type="checkbox"/> TPA | <input type="checkbox"/> OTHER_____ |
| Bill PHYSICALS to: | <input type="checkbox"/> Employer | <input type="checkbox"/> TPA | <input type="checkbox"/> OTHER_____ |
| Bill DRUG TEST to: | <input type="checkbox"/> Employer | <input type="checkbox"/> TPA | <input type="checkbox"/> OTHER_____ |
| Bill BAT to: | <input type="checkbox"/> Employer | <input type="checkbox"/> TPA | <input type="checkbox"/> OTHER_____ |
| Bill RTN TO WORK to: | <input type="checkbox"/> Employer | <input type="checkbox"/> TPA | <input type="checkbox"/> OTHER_____ |
| Bill _____ to: | <input type="checkbox"/> Employer | <input checked="" type="checkbox"/> TPA | <input type="checkbox"/> OTHER_____ |

Date info reviewed: _____

WORKMEN'S COMPENSATION COMPANY PROFILE

COMPANY _____ 0 _____

WORK COMP SERVICES

BILLING INFORMATION TO BE SENT TO: Employer or WKC Carrier

WKC Carrier Name: _____
(if applicable)

WKC Carrier Address _____
(if applicable)

LAB
Post accident drug testing

CASE I Yes No

Case Manager's Name: _____ Phone # _____

Job Duties or Physical Task Requirements provided Yes No

PRE AUTHORIZATION REQUIRED FOR THE FOLLOWING SERVICES
(indicate Yes or No)

CT SCANS	Yes <input type="checkbox"/>	No <input type="checkbox"/>
MRI SCANS	Yes <input type="checkbox"/>	No <input type="checkbox"/>
REFERRAL TO SPECIALIST	Yes <input type="checkbox"/>	No <input type="checkbox"/>
PHYSICAL THERAPY	Yes <input type="checkbox"/>	No <input type="checkbox"/>
ULTRA SOUND	Yes <input type="checkbox"/>	No <input type="checkbox"/>
OTHE _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>

SPECIAL INSTRUCTIONS:
