MyHealth URGENT CARE

AUTHORIZATION FOR OCCUPATIONAL HEALTH SERVICES

ALL services included in account profile for respective service WILL be performed unless otherwise stated.

Company Name _____Location _____
Employee or Prospective Employee Name _____
Company representative authorizing service_____Phone_____

DRUG AND ALCOHOL SCREENING:

☐ Regulated Drug Screen ☐ Non-Regulated Drug Screen ☐ ESCREEN E-Cup ☐ Breath Alcohol Testing

☐ Collection Only Urine Drug Screen (employer must provide CCF) ☐ Hair Collection ☐ No additional testing

REASON FOR TEST:

☐ Pre-Employment ☐ Random ☐ Reasonable Suspicion ☐ Follow-Up ☐ Return to duty

VACCINATIONS :

☐ PPD (Tuberculin skin test ONLY) ☐ Tetanus ☐ Influenza

PHYSICAL EXAMINATIONS:

☐ Pre-Employment Exam ☐ Return to Work Exam ☐ DOT Exam

By signing this authorization, said employer acknowledges full responsibility for payment for ALL services related to examinations, screening, diagnostic testing and treatment and or medications deemed necessary by the treating Physician for the authorized individual named in this form unless it is previously requested to collect payment at time of service from the individual. It is understood that services will be paid in full upon receipt of billing for all amounts due. It is also understood that the employer will be responsible for payment of all services related to injury or illness care of the employee if case is determined work related or not, or if the claim is denied by the workers' compensation insurance carrier.

**** Only complete when injury has occurred**

WORK RELATED INJURY/ILLNESS TREATMENT:

☐ Drug Screen ☐ Breath Alcohol Testing ☐ Non-Regulated ☐ Regulated

WORKERS COMPENSATION INFORMATION (unless billing direct to business):

INSURANCE NAME: _____ CLAIM NUMBER_____

CLAIM REPRESENTATIVE: _____ PHONE NUMBER_____

CLAIM ADDRESS: _____ CITY:_____ ZIP:_____

X_____ _____

Authorizing signature **DATE**