



PROPOSAL FOR SERVICES AUTHORIZATION FORM

Company Name / Responsible Party					
Billing Address					
City		State		Zip	
Phone		Email			

I hereby authorize and direct the above company that I represent to pay to Xpress Urgent Care such sums as may be due and owing him/her for medical services rendered my company for the administration of medical services per the following terms:

Services:	Proposed Fee per individual Service(s)
Drug Screen (all panels)	\$45
DOT Physical	\$110
Breath and Alcohol Testing	\$50
TOTAL:	\$205

I understand that I will be furnished with a detailed invoice for payment that will itemize the services rendered.

I further understand that such payment is not contingent on any other means by which I may eventually recover said fee.

If this account is assigned for collection and/or suit, collection cost and/or interest, and /or attorney’s fee, and/or court cost will be added to the total amount fee. If I disregard my financial responsibility, I understand I will be turned over to a collection agency, which may significantly affect my credit rating and that a 1099-C report will be made to the Internal Revenue Service.

Xpress Authorized Representative (Print)

Xpress Authorized Representative (Signature)

Date

Company Authorized Representative (Print)

Company Authorized Representative (Signature)

Date



Send completed to CorporateCare@xucfl.com

Company Information				
Company Name				
Address				
City			State	Zip
Phone #		Website		
Primary Point(s) of Contact <i>(Check off if they are authorized to receive notes, results, or other sensitive information)</i>				
Name	Title/Role	Direct Phone #	Email	YES
				<input type="checkbox"/>
				<input type="checkbox"/>
Primary Billing Contact for your company (required field):				
				<input type="checkbox"/>
Worker's Compensation Information				
Worker's Comp Carrier			Policy #	
Claims Address				
City			State	Zip
Assigned Adjustor Name		Phone #	Email	
Do you have a direct partnership with any third-party administrator? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, please complete the section below. If no, skip the TPA section.</i>				
TPA Information				
TPA Name				
Billing Address				
City			State	Zip
I understand that Xpress Urgent Care will be acting as a collection site and will not report out results for any services authorized by my third part administrator.				
<input type="checkbox"/> YES, I understand. <input type="checkbox"/> No, I would to discontinue using my TPA.				
Billing Information				
	Work Comp Carrier	Employer	Patient Responsibility	
Worker's Comp Claims bill to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Screens bill to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Exam, Vaccines, Titters & Specialty services bill to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Plan for the unXpected in your workplace Xpress Corporate Care

Authorized Services

Mark all services to be included in your profile as authorized services:

Pre-Employment Reasonable Suspicion Post- Accident

Collection ONLY - Chain of Custody provided

Drug Screens:

5 Panel - XUC Account 10 Panel - XUC Account DOT

Breath Alcohol Testing NON-DOT Breath Alcohol Testing DOT

Pre-Employment Basic Work Physical DOT Physical Exam

PPD 2- Step PPD Single View Chest X-Ray QuantiFeron Gold Blood Test

Audiometry Spirometry / Pulmonary Function Test Mask / Respirator Fit Test

Physical Exams:

Mask / Respirator Fit Test Mask / Respirator Questionnaire

CHECK if you have a specific physical exam request that is NOT listed.

Titers /
Diagnostic
Testing:

MMR Titer Varicella Titer Hepatitis B Titer

CHECK if you have a specific diagnostic testing request that is NOT listed.

Vaccines:

MMR Varicella Series (2 Vaccines Total) Hepatitis B Series (3 Vaccines Total)

Tdap (Tetanus - Diphtheria - Pertussis) Hepatitis A Series (2 Vaccines Total)

Seasonal Flu Vaccine

CHECK if you have a specific vaccine request that is NOT listed.

List any additional services requested
(we will review to determine if we are
able to offer these services):

Notes:

I confirm that the company information provided is accurate and understand this is NOT a contract but will be used for informational purposes internally at Xpress Urgent Care. All authorized services will be billed to the assigned party.

Company Representative Name _____ Title _____

Company Representative Signature _____ Date _____