

Send completed to [CorporateCare@xucfl.com](mailto: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
Primary Billing Contact for your company ( <b>required field</b> ):				
Worker's Compensation Information				
Worker's Comp Carrier			Policy #	
Claims Address				
City			State	Zip
Assigned Adjustor Name		Phone #	Email	
<p><b>Do you have a direct partnership with any third-party administrator?</b>      <input type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p><i>If yes, please complete the section below. If no, skip the TPA section.</i></p>				
TPA Information				
TPA Name				
Billing Address				
City			State	Zip
<p>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.</p> <p><input type="checkbox"/> YES, I understand.      <input type="checkbox"/> No, I would to discontinue using my TPA.</p>				
Billing Information				
	Work Comp Carrier	Employer	Patient Responsibility	
Worker's Comp Claims bill to				
Drug Screens bill to				
Physical Exam, Vaccines, Titters & Specialty services bill to				

## 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

Physical Exams:

Audiometry                       Spirometry / Pulmonary Function Test                       Mask / Respirator Fit Test

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 Dayana J Colmenares Date \_\_\_\_\_