



Xpress Corporate Care  
Email: MMonroy@XUCFL.com

### CORPORATE ACCOUNT FINANCIAL RESPONSIBILITY POLICY

We, Palm Beach Broward Landscaping (Company Name) agree(s) to pay in full for all authorized services rendered at Xpress Urgent Care upon the receipt of our invoice.

**Late Charge:**

Palm Beach Broward Landscaping (Company Name) understands that we are only financial responsible for any and all medical services, that we have authorized, including any post-accident drug screens not covered by our Worker's Compensation carrier. We understand that Xpress Urgent Care will provide us with a current statement monthly and it is our responsibility to pay our outstanding balance within 30 days of receipt of invoice.

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Accounts over 60 days past due may be subject to additional charges and may be sent to collections. We understand that we will be legally responsible for all collection costs involved with the collection of any delinquent account(s) including all court costs service charges (which may be up to 50%), reasonable attorney fees, and any and all other expenses incurred with collections.

**We have a right to request and receive an itemized statement for any and all charges or amounts invoiced.**

We understand that in the case of a disputed charge, it is our responsibility to notify the Xpress Urgent Care Billing Manager immediately upon receipt of our invoice, or within 30 days:

**Xpress Urgent Care – Corporate Billing  
ATTN: Billing Department  
1950 W Hillsboro Road  
Deerfield, FL 33442**

**Return Check Change:**

A returned check (for any reason) will result in an additional fee of \$30.00 per each occurrence due immediately upon receipt.

\*I acknowledge that I have received and understand the above Financial Responsibility policy.

[Signature]  
Authorized Signature (Corporate Client)

1/12/22  
Date

Jeanie Cummings  
Print Name

HRC / PR Manager  
Title

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For Customer Service Call 866.446.2848  
 Email [info@keyscriptsllc.com](mailto:info@keyscriptsllc.com)  
 Visit [keyscriptsllc.com](http://keyscriptsllc.com)  
 Fax 717.732.9467

Dear Injured Worker:

The attached KeyScripts Temporary Prescription Benefit Card will authorize you to obtain prescription medications related to your work injury, with no out-of-pocket expense, **but you must call to activate the card before taking it to the pharmacy.** The call takes only a few minutes. You will be asked for your name, date of birth, employer's name and telephone number, and your date of injury, so please have this information available when you call.

**CALL 866.446.2848 TO ACTIVATE YOUR CARD NOW**  
**YOUR ACCOUNT NAME IS: BUILDERS MUTUAL INSURANCE COMPANY**

Print your name and Employee ID number (provided to you during card activation) in the spaces provided on the card. Your card will be immediately activated after your call, and you may then take it to your pharmacy to fill your work injury prescription(s). *NOTE: There may be limitations on how much of your prescription can be filled, based on your employer's prescription benefit plan.*

**Do not attempt to use the KeyScripts card to fill any prescription other than those related to your work injury. Avoid filling any work-injury prescription directly at the prescribing physician's office, as most physicians do not accept prescription benefit cards similar to KeyScripts' for billing purposes.**

Please call KeyScripts customer service at 866.446.2848 with any questions regarding the use of your new card. From our robust national network of more than 70,000 pharmacies, you may visit your KeyScripts network pharmacy of choice – which includes all major retail pharmacies like CVS, Target, Walgreens, Walmart, Sam's Club and Costco – as well as most supermarket chain and grocery store pharmacies. Need help finding your nearest KeyScripts network pharmacy? Call us at 866.446.2848.

*Your KeyScripts Temporary Prescription Benefit Card contains important claims and customer service information for you and your pharmacist. After activation, present the card to your pharmacist when filling any prescription related to your work injury. You will receive a permanent card in the mail shortly.*

	For customer service, call 866.446.2848	<p><b>To the Employee:</b> Present this card to your KeyScripts Network Pharmacy of choice for any prescription drug related to your worker's compensation injury. This card is for identification purposes only, and your pharmacist may require additional/photo identification at time of fill. Unauthorized or fraudulent use of this card is punishable by law. We reserve the right to revoke this card at any time.</p>
<b>Bin #:</b> 009430 <b>Group ID:</b> BMIC0030	<b>Employee Name:</b> _____	<p><b>To the Pharmacy:</b> Submit claims via the ProCare System only for the person for whom the prescription was written.</p>
<b>Employee ID:</b> _____	<b>Workers' Compensation Prescription Benefit Card</b>	<p align="center"><b>ProCare Rx</b>          1267 Professional Parkway, Gainesville, GA 30507          Pharmacy Help Desk 1.800.277.1657</p>

# XPRESS URGENT CARE

## Company Information

Company Name <b>MDL Property Maintenance, Inc</b> <b>D/B/A Palm Beach Broward Landscaping</b>			
Address <b>11030 Blue Jay Lane</b>			
City <b>Boynton Beach</b>		State <b>FL</b>	Zip <b>33472</b>
Phone # <b>561-364-8610</b>	Website <b>Palm Beach Broward Landscaping</b>		

## Primary Point(s) of Contact

(Check off if they are authorized to receive notes, results, or other sensitive information)

Name	Title/Role	Direct Phone #	Email	YES
<b>Jeannie Cummings</b>	<b>HR/PR Mgr</b>	<b>561-364-8610</b>	<b>Jeannie @ PBLandscaping.com</b>	<input checked="" type="checkbox"/>
<b>Jessica Garcia</b>	<b>Admin</b>	<b>561-364-8610</b>	<b>Jessica @ PBLandscaping.com</b>	<input type="checkbox"/>

Primary Billing Contact for your company (required field):

<b>Jeannie Cummins</b>	<b>HR/PR Mgr</b>	<b>561-364-8610</b>	<b>Jeannie @ PBLandscaping.com</b>
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## Worker's Compensation Information

Worker's Comp Carrier <b>Builders Mutual Insurance Company</b>		Policy # <b>WCF108293400</b>
Claims Address <b>5580 Centerview Drive</b>		
City <b>Raleigh</b>		State <b>NC</b>
Zip <b>27624</b>		
Assigned Adjustor Name	Phone #	Email

Do you have a direct partnership with any third-party administrator?  YES  NO

If yes, please complete the section below. If no, skip the TPA section.

## TPA Information

TPA Name <b>N/A</b>		
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-party administrator.

YES, Report to my TPA.  No, Do not report to my TPA.

## Billing Information

	Work Comp Carrier	Employer	Patient Responsibility
Worker's Comp Claims bill to	<input checked="" type="checkbox"/>		
Drug Screens bill to	<input checked="" type="checkbox"/>		
Physical Exam, Vaccines, Titters & Specialty services bill to		<input checked="" type="checkbox"/>	

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## 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

Physical Exams:	<input type="checkbox"/> Pre-Employment Basic Work Physical		<input checked="" type="checkbox"/> DOT Physical Exam	
	<input type="checkbox"/> PPD	<input type="checkbox"/> 2- Step PPD	<input type="checkbox"/> Single View Chest X-Ray	<input type="checkbox"/> QuantiFeron Gold Blood Test
	<input type="checkbox"/> Audiometry		<input type="checkbox"/> Spirometry / Pulmonary Function Test	<input type="checkbox"/> 2- OSHA Questionnaire
	<input type="checkbox"/> Mask / Respirator Fit Test		<input type="checkbox"/> Mask / Respirator Questionnaire	
	<input type="checkbox"/> Mark if you have a specific physical exam request that is NOT listed.			
Titers / Diagnostic Testing:	<input type="checkbox"/> MMR		<input type="checkbox"/> Varicella	<input type="checkbox"/> Hepatitis B
	<input checked="" type="checkbox"/> Mark if you have a specific diagnostic testing request that is NOT listed.			
Vaccines:	<input type="checkbox"/> MMR		<input type="checkbox"/> Varicella Series (2 Vaccines Total)	
	<input type="checkbox"/> Tdap (Tetanus – Diptheria – Pertusiss)		<input type="checkbox"/> Hepatitis B Series (3 Vaccines Total)	
	<input type="checkbox"/> Hepatitis A Series (2 Vaccines Total)			
	<input type="checkbox"/> Seasonal Flu Vaccine			
<input checked="" type="checkbox"/> <b>CHECK if you have a specific vaccine request that is NOT listed.</b>				
List any additional services requested (we will review to determine if we are able to offer these services):			COVID	



**PROPOSAL FOR SERVICES AUTHORIZATION FORM**

Company Name / Responsible Party	<b>PBB LANSCAPING</b>				
Billing Address	11030 BLUE JAY LANE				
City	BOYNTON BEACH	State	FL	Zip	33472
Phone	561-364-8610	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 (5 panel)	\$50
DOT physical	\$110
Covid Testing	\$65

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.**

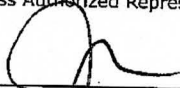
If this account is assigned for collection and/or suit, collection cost and/or interest, and /or attorney's fee, and/or court cost will be added to the total amount fee. If I disregard my financial responsibility, I understand I will be turned over to a collection agency, which may significantly affect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

RAO I PUENTE  
Xpress Authorized Representative (Print)

  
Xpress Authorized Representative (Signature)

4/12/2022  
Date

Jeanne Cummings  
Company Authorized Representative (Print)

  
Company Authorized Representative (Signature)

1/12/22  
Date



Xpress Corporate Care  
Email: MMonroy@XUCFL.com

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MDL Property Maintenance  
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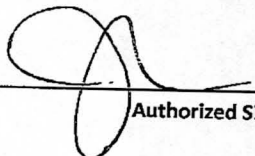
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\_\_\_\_\_  
Authorized Signature (Corporate Client)  
  
Jeannie Cummings  
\_\_\_\_\_  
Print Name

1/12/22  
\_\_\_\_\_  
Date  
  
HR/PR Manager  
\_\_\_\_\_  
Title

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## Occupational Health Superbill

Physicals		
Work Physical Exam	XWPE	\$ 65.00
US Coast Guard Physical Exam	XUSCG	\$ 150.00
DOT Physical Exam	XDOT	\$ 110.00
Mask / Respirator Fit Test	XFIT	\$ 65.00
Mask / Respirator Questionnaire (OSHA)	XORQ	\$ 65.00

Drug Screens		
Breath Alcohol Test	82075	\$ 50.00
Collection Fee Drug Screen	XDSC	\$ 25.00
Drug Screen, Urine ( ALL PANELS - 5 / 7 / 9 / 10 / 12 Panel)	80300	\$ 50.00

COVID Testing Options		
COVID Testing (PCR)	87635	\$ 65.00

Non- Occ Health Visits		
School Immunization Form BLUE		\$ 25.00
School Physical Exam Form YELLOW		\$ 25.00
School SPORTS Physical Exam		\$ 25.00
Camp Physical Exam		\$ 25.00
College Physical Exam <i>(excludes nursing for internships)</i>	S0622	\$ 50.00
<b>Use pricing on this Superbill if "Add-On" services are required for completion of physical exam.</b>		

Physical Services – Add On Services ONLY		
Audiometry	92551	\$ 45.00
CBC - Complete Blood Count	85027	\$ 30.00
CMP - Comprehensive Metabolic Panel	80053	\$ 40.00
Chest X-Ray - PA / Lateral Views (2 View)	71020	\$ 80.00
Chest X-Ray - Single View for Positive PPD		\$ 65.00
EKG	93000	\$ 70.00
Hepatitis A Vaccine	90632	\$ 115.00
Hepatitis B Titer	86706	\$ 35.00
Hepatitis B Vaccine	90747	\$ 90.00
Lipid Panel	80061	\$ 50.00
Measles Titer	86765	\$ 25.00
MMR Titer		\$ 75.00
MMR Vaccine	90707	\$ 85.00
Mumps Titer	86735	\$ 25.00
PPD / Tuberculosis Skin Test	86580	\$ 35.00
QuantiFERON Gold - TB Blood Screening	86480	\$ 175.00
Rubella Titer	86762	\$ 25.00
Spirometry	94010	\$ 40.00
Tdap	90715	\$ 70.00
Varicella Titer	86787	\$ 35.00
Varicella Vaccine	90716	\$ 150.00



## EMPLOYEE AUTHORIZATION FOR SERVICES

To be Submitted by Employee and Signed by Employee & Authorizing Employer

<b>Company Name:</b>	
<b>Authorized By:</b>	
<b>Company Contact Number:</b>	

<b>Patient (Employee) Name:</b>	
<b>Date of Birth:</b>	<b>Social Security Number:</b>

**Is this a Worker's Comp Visit? (On the Job Injury)** Complete section below for a Workers Comp visit.

Is there a Post-Accident Drug Screen?  Yes  No

Has the Patient been given a Chain of Custody Form?  Yes  No

Collection Only   
  5 Panel   
  7 Panel   
  10 Panel   
  DOT Federal  
 Breath Alcohol Test   
  Drug Screen-Hair Collection

<b>Work Comp Insurance Carrier:</b>	<b>Date of Injury:</b>
<b>Adjuster (If known):</b>	<b>Claim Number (If known):</b>

**Should medications be sent to a specific pharmacy?**  Yes  No

**Is this an Occupational Health Visit?** Complete this section for a non-Workers Comp related visit.

<input type="checkbox"/> Work Physical	<input type="checkbox"/> PPD	<input type="checkbox"/> Chest X-Ray (For Positive PPD)
<input type="checkbox"/> QuantiFeron Gold TB Test	<input type="checkbox"/> Hep B Vaccine (series of 3)	<input type="checkbox"/> Hep A Vaccine (Series of 2)
<input type="checkbox"/> MMR Titer	<input type="checkbox"/> Varicella Titer	<input type="checkbox"/> Flu Vaccine

Pre-Employment Drug Screen:

Collection Only   
  5 Panel   
  7 Panel   
  10 Panel   
  DOT Federal

**List any requested services not included in the option list above:**

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**Special Instructions:** \_\_\_\_\_

**EMPLOYER AUTHORIZATION:** I authorize the above services and understand that my company will be responsible for all services not covered by my Worker's Compensation carrier, including Post-Accident drug screens and breath alcohol tests. I understand that if a claim number is not provided to Xpress Urgent Care in order for them to submit to my Worker's Compensation carrier, that I will be responsible for payment for the treatment of this employee.

**Signature of Authorizing Company Supervisor:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PATIENT AUTHORIZATION FOR MEDICAL RECORD RELEASE:** I, (Employee's Name) \_\_\_\_\_, do hereby authorize the release and disclosure of medical records, information, and drug screen results pertaining to my work related injury from the medical facility that treated my work related injury to my employer, \_\_\_\_\_'s Human Resource Department. This authorization is valid for one year from the date signed. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting my revocation request in writing to the Medical Records department.

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_