
Primary and Urgent Care Centers Instructions

St. Lucie Primary Contacts:

Susan Carver

Director of Risk Management & Employee Benefits
772-429-5526 office
susan.carver@stlucieschools.org

Carmen Ortiz

Risk Management Specialist
772-429-5525 office
carmen.ortiz@stlucieschools.org

Relation Insurance Services - Third Party Administrator:

Kathy Sears

Sr. Lost Time Adjuster
772-919-8658 direct / 772-210-4846 fax
Kathy.Sears@relationinsurance.com

Cortney Gomer

Manager, Workers' Compensation Claims
772-919-8621 direct
cortney.gomer@relationinsurance.com

Yolanda Williams-Dover

Medical Only Claims Adjuster
772-919-8662 direct / 772-210-4842 fax
yolanda.williams@relationinsurance.com

Ronda Moore

Nurse Case Manager
772-919-8673 direct / 772-210-4850 fax
ronda.moore@relationinsurance.com

Work Status / DWC-25:

- Must be completed the day of the appointment with work status in a clear and concise manner and faxed to Yolanda Williams-Dover at Relation at 772-210-4842 and include Carmen Ortiz by email carmen.ortiz@stlucieschools.org
- A copy of the DWC-25 must also be given to the patient and confirm their understanding of any restrictions or referrals. Prescription pad notes are discouraged. Please include the employee's time in and time out.
- Physical restrictions MUST be documented on page 2 of the DWC-25. If there are no restrictions, document by checking that box (box 21).
- Restrictions must apply to the physical capability of the employee, for example, "no lifting, pushing, pulling over 10 lbs." Restrictions such as "no working with kids", "return to work as tolerated" or "should avoid teaching" are not acceptable.
- Providers shall not refer patients to any other medical provider or diagnostic testing center. All referrals will be coordinated solely by Relation.
- **Do not dispense prescriptions.** The injured employee is to go to their local pharmacy to fill any work-related prescribed medication.
- If a follow up appointment is necessary, then it must be scheduled prior to the patient leaving, and should also be reflected on the DWC-25. **The appointment should be made outside the employees working hours (ask them what hours they work).**
- All medical bills should be sent to the billing address listed below.

Return to Work Program:

The School District has an aggressive return to work program. Most work restrictions can be accommodated, and employees will return to work according to Dr. ordered work restrictions.

Special Handling Instructions:

- **Address work status at every appointment. Address specific restrictions**, not the employee's job. The School District has an aggressive return to work program. Light duty is available for almost every employee with a few exceptions. Employees are accommodated and will return to work within restrictions, even at an alternative location. **Fax the DWC-25 within ONE business day of physician appointment to Relation adjuster at # 772-210-4842.** For any questions regarding treatment or handling, contact Relation at 772-919-8662 or 800-431-2221.

MMI:

- Maximum Medical Improvement dates should be final.
- Permanent restrictions should remain permanent. If a patient's condition dramatically improves, then a detailed report outlining the reasons why the permanent restrictions should be changed must be provided to Relation adjuster.
- If a patient's condition is expected to improve, we would rather you wait to place the patient at MMI until most reasonable improvement is achieved.

Written Inquiries:

- A reply to a request from RELATION for clarification on a patient's medical treatment should be responded to within 48 hours (ie: MCC letter).

PLEASE SUBMIT ALL BILLING TO:

Relation Insurance Services of Florida
700 SE Central Parkway
Stuart, FL 34994

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
Primary Billing Contact for your company (required field):				
Worker's Compensation Information				
Worker's Comp Carrier			Policy #	
Claims Address				
City			State	Zip
Assigned Adjustor Name		Phone #	Email	
<p>Do you have a direct partnership with any third-party administrator? <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 _____ Date _____