Employer's Authorization FOR TREATMENT

Atrium Health
Now part of ADVOCATEHEALTH

Employee Name: _____ DOB: _____ Phone Number: _____

Authorized By: _____ Authorization Good Through: _____

Employer Contact

Employer or Third Party Administrator (TPA): _____

Address: _____

Email: _____ Fax: _____

Contact: _____ Phone Number: _____

Preferred Communication Method: _____

Reason for Visit ☐ Pre-employment ☐ Random ☐ Post Accident ☐ Reasonable Suspicion/Cause ☐ Other

Services Available

Drug Screen Collections/ Alcohol Screenings:

Reason (check all that apply)

☐ DOT Drug Screen

☐ DOT/Non-DOT Collection Only

(Must provide COC)

☐ Breath Alcohol/Confirmation

- ☐ DOT
- ☐ Non-DOT

Rapid Urine Drug Screening:

Pre-employment only

☐ 6 Panel Urine*

☐ 10 Panel Urine*

☐ 5 Panel Saliva*

☐ 6 Panel Saliva*

☐ 8 Panel Saliva*

Non-DOT Urine Drug Screening:

☐ 5 Panel Urine

☐ 9 Panel Urine

☐ 10 Panel Urine

☐ 12 PanelUrine

☐ 6 Panel Saliva*

☐ 7 Panel Saliva*

☐ 9 Panel Saliva*

☐ 9 Panel Saliva (no THC)*

☐ 10 Panel Saliva*

Physical Examinations:

☐ Non-DOT Physical

☐ DOT Physical

☐ Firefighter Physical*

X-rays (Pre-employment/ Post-offer)

☐ Chest X-ray (1 View)

☐ Chest X-ray (2 Views)

Other Services/Tests:

☐ Audiometry ☐ EKG* ☐ Fit Testing* (bring your respirator) ☐ Hepatitis B Titer ☐ Hepatitis B Vaccine

☐ Tetanus Vaccine ☐ Respirator Clearance Questionnaire ☐ Spirometry ☐ Tuberculosis Testing/PPD**

☐ Vision Testing ☐ Tuberculosis Blood Test-QuantiFERON** ☐ Other Services (explain)

_____

_____

_____

* Only performed at select locations

** Chest X-ray authorized for positive TB test

Required for All Workers' Compensation (W/C) Visits

Injury Description: _____

☐ Post accident drug screen

☐ Workers' Compensation Injury Treatment Date of Injury: _____ Claim Number: _____

Where are claims to be filed? ☐ Bill Employer ☐ Insurance Carrier W/C Carrier Name: _____

W/C Carrier Address: _____

W/C Carrier Phone: _____ W/C Carrier Fax: _____ Policy Number: _____

Occ Med Direct Bill Information

☐ Bill Established Employer Account (account must be current – no past due balance)

☐ Bill New Credit Card Name on Card: _____ Card Number: _____

Exp. Date: _____ CV Code: _____ Card Mailing Address: _____

City: _____ State: _____ Zip: _____ ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Employer Representative Signature: _____ Date: _____

Please submit documents to (name/email/fax): _____