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* ☐ 5 Panel Saliva*

☐ 10 Panel Urine* ☐ 6 Panel Saliva*

☐ 8 Panel Saliva*

Non-DOT Urine Drug Screening:

☐ 5 Panel Urine ☐ 6 Panel Saliva*

☐ 9 Panel Urine ☐ 7 Panel Saliva*

☐ 10 Panel Urine ☐ 9 Panel Saliva*

☐ 12 PanelUrine ☐ 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)

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* 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): ____________________

Current as of 8/24/2023