TOTAL ACCESS URGENT CARE

Med Auth Form

1) Visit Type

☐ Occ Med

☐ Work Comp (Specify Body Part) _____

2) Registration

Employee	Authorizing Official
Employee Name_____	Name (Printed)_____
Employee SSN_____	Name (Signature or Verbal) _____
Date of Injury_____	Date_____

By signing or verbally authorizing this authorization, the above referenced company acknowledges and agrees that it is fiscally responsible for all incurred charges, whether work related or non-work related. Charges may be submitted to the above referenced company's Worker's Compensation carrier at the company's discretion but failure to submit charges to the Worker's Compensation carrier does not relieve the company of the responsibility for these charges.

Company Information

Company Name_____

Address_____

City_____ State___ Zip_____

Phone_____ Ext _____

Secure Fax_____

Authorizing Official's Email_____

Who will be Paying this Claim?

☐ **Company Directly** ☐ **Company's Insurance Carrier**

If Company's Insurance Carrier is paying, fill info below.

Insurance Name_____

Claim Number_____

Insurance Contact/Title _____

Insurance Phone Number_____

3) Evaluation Information

Visit Reason (Select 1)

☐ Pre-Employment
☐ Random
☐ Reasonable Suspicion
☐ Post-Accident
☐ COVID-19 Swab
☐ Other (Write Below)

_____

Drug Screen and/or Breath Alcohol? (Up to 2)

☐ DOT Drug Screen
☐ Non-DOT 5-Panel Drug Screen (Rapid/Default)
☐ Non-DOT 5-Panel Drug Screen (Send-Out)
☐ Non-DOT 10-Panel Drug Screen (Rapid/Default)
☐ Non-DOT 10-Panel Drug Screen (Send-Out)
☐ Breath Alcohol Test

Extra (Employer's Choice)

☐ DOT Physical
☐ Flu Shot
☐ Hep A
☐ Hep B
☐ Physical
☐ PPD (TB Skin Test)
☐ Other (Write Below)

_____

Date:_____ TAUC Registrar Initials: _____

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