

TOTAL ACCESS URGENT CARE

Med Auth Form

1) Visit Type

- Occ Med
- Work Comp (Specify Body Part) _____

2) Registration

Employee

Employee Name _____
 Employee SSN _____
 Date of Injury _____

Authorizing Official

Name (Printed) _____
 Name (Signature or Verbal) _____
 Billing/HR Contact _____
 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)

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

Date: _____

TAUC Registrar Initials: _____