

Occupational Medicine: New Company Information Form

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Company Information:

Company Name:

Address: Address:

City: State: Zip:

Phone: Fax: Service Industry?

Billing Information:

Billing Contact:

Address: Address:

City: State: Zip:

Phone: Fax: ACH Payment? Yes No

Email Invoices? Yes No Email for Invoice:

Account Services:

Main Contact for Service Related Questions:

Office Phone: Cell Phone: Email:

Second Contact:

Office Phone: Cell Phone: Email:

Safety/Injury Contact:

Office Phone: Cell Phone: Email:

Services Needed:

Physicals:

DOT-CDL DOT-USCG Non-DOT Routine UKOOA/OGUK Crane Operator Hazmat Return to Duty

Screenings:

DOT DS (SouthStar as MRO) Non-DOT DS (SouthStar as MRO) Quick Screens

DS Collection Only (Company has own CCF) LAB:

DOT Breath Alcohol Non-DOT Breath Alcohol (company has own form)

OCC Med Services:

3-View Back X-Ray 5-View Back X-Ray 2-View Chest X-Ray 1-View Chest X-Ray Lift Capacity Evaluation

Audio Pulmonary Function Test Respirator Fit Test Model:

Full Face Half Face Other:

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Results:

How would you like results send to you? Fax Email

If Fax: Fax Recipient: Fax #:

If Email: Email Address:

Password: 6 or LESS Characters

Authorization:

Does your company have their own Authorization? Yes No

How will you send in the Authorization? Fax Email With Employee

Third Party Administrator (TPA):

Company Name:

Address:

City: State: Zip:

Phone: Fax:

What services will be billed to this TPA?:

Worker's Comp. Information:

Company Name:

Address: Address:

City: State: Zip:

Phone: Fax: