

Employer Occupational Health Services

Customized services to meet your needs... Provide us with the information that applies to your business. When you need to utilize Work Comp or Screening services, your specifications will be clearly outlined. It's that easy! If you have any further questions, please contact:

Rose Huynh, Occupational Healthcare Representative
rose@memorialpromptcare.com
714/378-0900 x 242 / Fax 714/908-5996

Memorial Prompt Care location(s) you will be utilizing:

- 18561 Beach Blvd. @ Main St. (714) 848-0080
- 15464 Goldenwest St. @ McFadden Ave. (714) 891-9008
- 9122 Adams Ave. @ Magnolia St. (714) 378-0900

Employer Information	<input type="checkbox"/> #
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Name _____ Store/Location # _____
Location Street Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____
Type of Business _____
Hours / Days of Operation _____ Note
Employer Billing Contact Person _____ # of employees _____
E-mail Address _____

Treatment Authorization & Work Status Reporting	<input type="checkbox"/>
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Contact _____ Phone _____
E-mail Address _____

Your employee leaves our office with an Employer & a Patient copy of the Work Status Report.
Indicate special reporting needs of the Initial status: FAX Phone Note

Modified Duty Available?: <input type="checkbox"/> Always <input type="checkbox"/> Never <input type="checkbox"/> Varies	<input type="checkbox"/>
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Worker's Comp Insurance Carrier Information (Not Insurance Broker)	<input type="checkbox"/> #
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Insurance Carrier _____ Policy # _____
Address _____
Phone _____ Fax # _____

Billing Employer Directly for Injuries*	<input type="checkbox"/> #
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- First Aide Cases *ONLY* **ALWAYS**, unless instructed otherwise
- NEVER** Bill Employer, Always bill W/C Carrier

Note

How did you hear about our office/services available?

- Sign on Building Another Employer: _____
- Yellow Page Ad Occupational Healthcare Representative
- Insurance Carrier Additional services requested or information update
- Other: _____

*Payment Terms (Applies to Bill Company Direct Injuries and Screening Services)

I agree to make full payment within 20 days of the invoice. I understand that services will not be rendered to my employees unless this agreement is signed and returned.

Signature _____ Title _____ Date _____

Return by FAX to 714/ 908-5996

Screening Services (Complete if applicable)

Employer Name: _____

Screening Result Reporting	<input type="checkbox"/> Account #
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Contact _____ Phone _____

Contact _____ Phone _____

FAX _____ Secure? E-mail _____

Address (if different) _____

Reporting Requirements: Phone FAX Mail Send with Patient Other _____

Indicator/Position	Code	Menu of Service Options	Fee
	99429	Pre-Placement Exam	
	90751 81002	DMV Exam including vision Urinalysis – Chemistry only	
		<i>Total DMV</i>	
	99428	Annual Screening Exam	
	99385	Comprehensive Exam/Executive Physical	
	97670	Back Screening Exam (Functional Capacity)	
	97750,1	Grip Strength Testing (Jamar Test)	
	80100,1	Rapid Urine Drug Screen	
	80100,4	D.O.T. Urine Drug Screen	
	99000,1	Drug Screen Collection only	
	86580	TB Mantoux Skin Test	
	71010	- X-Ray: 1 view Chest with all positive TB results	
	81002	Urinalysis – Chemistry only	
	81000	Urinalysis – Complete w/microscopic	
	82075	Breath Alcohol Testing – Westminster location only	
	80102,1	- w/Confirmation - Westminster location only	
	92551	Hearing Test (Audiogram)	
		- Review Audio history results & certificate	
	92081	Vision Test (Orthorator)	
	94010	Pulmonary Function Test	
	94010,1	- Respirator Exam (review history form & certificate)	
	72100	X-Ray: 2 view Back	
	71010	X-Ray: 1 view Chest	
	71020	X-Ray: 2 view Chest	
	90632	Vaccination: Hepatitis A (\$80.00 x 2 doses)	
	90746	Vaccination: Hepatitis B (\$65.00 x 3 doses)	
	90658	Vaccination: Flu (price & availability varies each season)	
	90714	Vaccination: Tetanus & Diphtheria (Td) <i>preservative free</i>	
	85024	CBC w/Differential	
	80053	Comprehensive Metabolic Panel #1369	
	~3216	Lipid/Cardiac Risk Profile (Chol, Tg, LDH, LDL, Ratio)	
	93000	EKG w/Interpretation	
	93015	Treadmill Stress Test	
	45330	Flexible Sigmoidoscopy	

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Signature _____ Title _____ Date _____

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