Company Profile

A) General Information:

Company Name: _____

Phone Number: _____

Fax Number: _____

Street Address: _____

City, State, Zip: _____

Mailing Address: _____

B) Main Contact Information:

Person: _____ Title: _____

Phone: _____ Fax: _____

E-mail: _____ Mobile: _____

C) Services Required

Substance Testing

□ Collection Only **□ Complete Screening** **□ Rapid/Quick Dip Drug Screen**

Drug Screen
□ Non-regulated
__ Pre-employment
__ Post-accident
__ Random
__ Reasonable Suspicion
__ Follow-up

Drug Screen
□ Regulated (DOT)
__ Pre-employment
__ Post-accident
__ Random
__ Reasonable Suspicion
__ Follow-up

Breath Alcohol (BAT)
□ Non-regulated
__ Pre-employment
__ Post-accident
__ Random
__ Reasonable Suspicion
__ Follow-up

Breath Alcohol (BAT)
□ Non-regulated
__ Pre-employment
__ Post-accident
__ Random
__ Reasonable Suspicion
__ Follow-up

Please specify how you would like to receive results:

Secured Fax: _____ E-mail: _____

Mail (Confidential): _____

Primary Contact: _____ Phone: _____

Secondary Contact: _____ Phone: _____

Physical Exams

☐ Pre-employment ☐ DOT ☐ Annual Exam ☐ _____

Please specify how you would like to receive results:

Secured Fax: _____ E-mail: _____

Mail (Confidential): _____

Contact: _____ Phone: _____

Injury Care

Primary Contact: _____ Phone: _____

Secondary Contact: _____ Phone: _____

Is Modified/Light duty available?_____

☐ Post-Accident Drug Screen required ☐ Post-Accident BAT required

Other Services

☐ Audiometry
☐ Vision Testing
☐ PFT/Spirometry
☐ Tetanus
☐ Tb Testing
☐ Hepatitis A/B
☐ Chest X-Ray
☐ Other: _____

Additional Information: _____

_____

_____

Special Instructions / Protocols: _____

_____

_____

D) *Injury Care* Billing Information:

Insurance Co: _____ Phone: _____

Billing Address: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

Policy / Claim Number: _____

Type of Bill: ☐ Invoice ☐ TWCC73 ☐ HCFA

E) *Substance Test* Billing Information:

Insurance Co: _____ Phone: _____

Billing Address: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

Policy / Claim Number: _____

Type of Bill: ☐ Invoice ☐ TWCC73 ☐ HCFA

F) *Physical Exam* Billing Information:

Insurance Co: _____ Phone: _____

Billing Address: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

Policy / Claim Number: _____

Type of Bill: ☐ Invoice ☐ TWCC73 ☐ HCFA