DePaul Community Health Centers

Occupational Health – New Company Setup Form

Date: _____

Company Information

Company Name: _____

Main Contact Person: _____ Title/Position: _____

Phone: _____ Email: _____

Fax (if applicable): _____

Company Address: _____

City _____ State _____ ZIP _____

Billing Entity: ☐ Same as Employer ☐ Third Party (specify):

_____

Company Details

Type of Account:

☐ Employment Physicals (EPS) ☐ Workers' Compensation (WC) ☐ Both

Industry Type: _____

Approx. Number of Employees: _____

Services

Services Requested:

☐ Pre-Employment Physicals ☐ Drug & Alcohol Testing ☐ Immunisations / Titres

☐ Fit-for-Duty / Return-to-Work ☐ Injury Management (Workers' Comp)

☐ Health Surveillance (Audiogram, Spirometry, etc.)

☐ Other: _____

Expected Volume (monthly): _____

Mobile Services Required? ☐ Yes ☐ No

Workers' Compensation (if applicable)

WC Carrier Name: _____ Carrier Phone: _____

Carrier Fax: _____ Claim Number Required for Visit Entry? ☐ Yes ☐ No

Adjuster Name: _____ Adjuster Contact Info: _____

Billing Address for WC Claims: _____

Attach WC Authorization Template or SOP: ☐ Yes ☐ No

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