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

DEPAUL COMMUNITY
HEALTH CENTERS

Workers' Compensation (if applicable)

WC Carrier Name: ______________________ Carrier Phone: ______________________

Carrier Fax: ______________________ Claim Number Required? ☐ Yes ☐ No

Adjuster Name: ______________________ Adjuster Contact Info: ______________________

Billing Address for WC Claims: ____

Attach WC Authorization Template or SOP: ☐ Yes ☐ No