Employer Authorization Form

Patient must present Photo ID and Authorization Form at time of service

SECTION I:	**PATIENT INFORMATION**		
Last Name		First Name	
Date of Birth (MM/DD/YYYY)		SSAN	
SECTION II:	**COMPANY INFORMATION**		
Employer Name		Fast Pace Account #	
Primary Contact		Phone Number	
Address City, State, ZIP		Email	

SECTION III: AUTHORIZED SERVICES (check all that apply for this visit)

☐ Urine Collection Only (80306)	Federal / DOT (80306)	10 Panel eScreen Insatant (eCup+)(80306)
☐ Observed Fee (99211OF)	10 Panel Lab (80306)	TN Drug Free (80306)
☐ DOT Physical (99455)	Pre-Employment Physical (99455ND)	Breath Alcohol Test (82075)
☐ Flu Vaccine (90686)	Immunization Administration (90471)	Fit for Duty Physical (97161)
☐ Tetanus, (Tdap) (90715)	Hep B Titer (86706)	Tetanus, Diphtheria (90714)
☐ Hep A Titer (86708)	Hepatitis C Panel (87522)	Hep C Titer (86803)
☐ Hepatitis Panel 4 (80074)	PPD/TB Gold/Blood (86480)	MMR Titer (86735, 86765, 86762)
☐ PPD (TB Test) (86580)	Venipuncture (36415)	PPD Questionnaire (86580Q)
☐ EKG (93000)	Color Vision Exam – Ishihara	Varicella Titer (86787)
☐ Visual Acuity Test – Snellen (99173)	(92283BCS) Non-DOT Physicals	Chest X-ray 1 or 2 view (71046)
☐ Pure Tone Audiometry (92551)	Lift test (97161)	

Employer is a participant of the Federal Drug Free Work Force program: ☐ Yes (Program requires Lab Based UDS) ☐ No

☐ Pre-Employment ☐ Reasonable Suspicion ☐ Random
☐ Post-Accident/Post Injury ☐ DOT Return to Work (Observed-Federal COC)

SECTION IV: WORKERS' COMPENSATION

☐ Workers' Compensation Injury Treatment
Date of Injury:_________________ Type of Injury: ____
W/C Authorization Number: ____
Where are claims to be filed? ☐ Bill Employer ☐ Insurance Carrier
W/C Carrier Name: ____
W/C Carrier Address: ____
W/C Carrier Phone:____________________ W/C Carrier Fax:______________________Policy Number:_________________________

SECTION V: CUSTOMER ACKNOWLEDGEMENT

EMPLOYER: This certifies that the above information is correct. I authorize the medical provider to provide medical treatment to the employee named above. I also understand that the services provided will be paid in full by the company listed above and authorized by my signature.

X_______________________________________ _________ ______________________________________ __________

Employer Authorized Signature (Required) **Date** **Employer Printed Name (Required)** **Title**