Bee  Well

URGENT CARE

PATIENT MUST PRESENT PHOTO ID AND AUTHORIZATION FORM AT THE TIME OF SERVICE

FORM AUTHORIZING EXAMINATION OR TREATMENT

EMPLOYER INFORMATION

Employer:		Work Comp Payer:	
Employer Contact Person:		Work Comp Claim Number:	
Employer Contact Phone:		Work Comp Payer Address:	
Employer Contact Email:		Work Comp Payer Email:	
Date of Incident (MM/DD/YYYY):		Work Comp Payer Fax:	

PATIENT INFORMATION

First Name:		Last Name:		Middle Initial:	
Date of Birth (MM/DD/YYYY):		Social Security Number:			

REQUESTED SERVICES

Drug Screens **Authorized Services:** In Office ☐ Send Out ☐

Pre-Employment Drug Screen ☐ Post-Accident Drug Screen ☐ Random Drug Screen ☐ DOT Drug Screen ☐

Physicals

- Non-DOT/Pre-employment ☐
- Fit for Duty ☐
- DOT/DOE Physical ☐
- Basic Physical ☐

Diagnostic

- Blood Work ☐
- Urine Analysis ☐
- X-Ray ☐
- Wound Eval/Repar/Treatment/Culture ☐
- Splinting ☐
- Other ☐

Other

- Tetanus Shot (Tdap) ☐

Workers' Compensation

Injury ☐ Illness ☐

Injury/Illness Details:

Secondary Illness Related to Injury Details:

Billing Directions: Employer ☐ Worker Compensation Insurance ☐

NOTES AND ADDITIONAL SERVICES

EMPLOYER AUTHORIZATION

Signature:	Date (MM/DD/YYYY):