



Company Profile/Account Set-up

This form is vital to insure procedures are followed correctly. Should one of your employees utilize the Occucare Clinics, this form will provide a protocol to follow and contacts to call.

Thank you for your prompt response.

Company Name: _____

Type of Business: _____

Physical Address: _____

Telephone #: _____ Fax #: _____ Private/Secure Fax #: _____

Results mailing Address: _____

Results Mailed Attention to: _____

Billing Address: _____

Do you bill Insurance for injuries or are you self-insured? _____

For processing payment, if your company uses ACH/EFT, please email Deanna Finney @ dfinney@occucareinternational.com or call @ 281-241-8224

W/C Carrier Name: _____

W/C Carrier Billing Address: _____

W/C Carrier Telephone #: _____ W/C Carrier Fax #: _____

Is there a PO # (Blanket) or a job site to bill by? _____

Are there multiple locations that need different protocols, billing or results contact information? (If yes, please contact office in order to work sort out details to ensure accurate reporting and billing)

Contacts; (please include the phone, fax, email and location address for each contact)

HR: _____

DER (results): _____

Billing Department: _____

Collections Department: _____

Who can authorize treatment: _____

People authorized to receive results: _____

Safety & Supervisors: _____

Post Accident DS ____ Yes ____ No

Post accident ALCO _____ Yes _____ No

If yes; what kind of drug screen and alco? _____

Are you OSHA sensitive? _____

Do you have light duty? _____