MARTINEZ URGENT CARE

210 OAK STREET
MARTINEZ, GA 30907
OFFICE: 706-855-1755
FACSIMILE: 706-863-2587
FAMILY PRACTICE & OCCUPATIONAL MEDICINE

COMPANY DEMOGRAPHICS

COMPANY NAME: _____ EMPLOYEES NAME: _____

COMPANY ADDRESS: _____ CITY: _____

STATE: _____ZIP:_____ PHONE: _____FAX: _____

POINT OF CONTACT FOR COMPANY: _____

PHONE: _____ EMAIL: _____

SERVICE DETAILS

POST ACCIDENT DRUG SCREEN? ☐NO. ☐YES.
IF YES, WHICH TYPE? ☐ 5-PANEL INSTANT ☐ 10-PANEL INSTANT ☐ NON - DOT ☐ DOT
WHO WILL BE PAYING FOR THE DRUG SCREEN? ☐COMPANY ☐INSURER
WILL YOU BE REQUESTING A COPY OF MEDICAL RECORDS? ☐ NO. ☐ YES.
PREFERRED METHOD OF RECEIVING RECORDS: _____

IF YOU HAVE A SPECIFIC PANEL FOR REFERRALS, PLEASE LET US KNOW BECAUSE WE WILL NOT BE ABLE TO MAKE ANY REFERRALS WITHOUT THIS INFORMATION.

WORKERS COMPENSATION BILLING & CLAIM INFORMATION

W/C INSURANCE COMPANY: _____

W/C INSURANCE BILLING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

CLAIM/ REF #: _____ ADJUSTER: _____

ADJUSTER CONTACT INFO: _____

DATE REPORTED: _____ TIME: _____REPORTED BY: _____

NAME OF PERSON AUTHORIZING MEDICAL TREATMENT: _____ TITLE: _____

BILLING INFORMATION IF NOT FILING WITH WORKERS COMPENSATION INSURANCE

RESPONSIBLE PARTY FOR PAYMENT: _____PHONE:_____

PERSON AUTHORIZING PAYMENT AGREEMENT: _____ TITLE: _____

ADDRESS FOR BILLING STATEMENT (if different from co. address): _____

_____ PHONE: _____

CREDIT CARD NUMBER:_____ EXPIRATION DATE:_____

CVV CODE:_____ BILLING ZIP CODE:_____ NAME ON CARD:_____

AS THE EMPLOYER, I, _____, ACKNOWLEDGE THAT IT IS MY RESPONSIBILITY TO SUBMIT ALL NECESSARY WORKERS COMPENSATION DOCUMENTS TO ENSURE TIMELY PAYMENT OF MY EMPLOYEE'S AUTHORIZED MEDICAL TREATMENT.

_____ AGREES TO FURNISH PAYMENT TO MARTINEZ URGENT CARE FOR AUTHORIZED SERVICES RENDERED TO MY EMPLOYEE WITHIN 30 DAYS OF RECEIPT OF BILL, AS MANDATED BY GEORGIA STATE WORKERS COMPENSATION, O.C.G.A. 34-9-203.

SIGNATURE OF AUTHORIZED EMPLOYER: DATE: