direct REHABMED BUSINESS HEALTH

Company Profile Form

Company Name	
Company billing address	
Billing Telephone	
Billing Fax	
Company Contact / Title	
Local Address (if different)	
Local Telephone	
Local Fax	
Local Contact / Title	
Consortium?	
Consortium billing address	

Insurance Information for Work Injuries

○ Self Insured	○ Texas Workers' Comp		○ Other
Will we handle your work Injuries?	○ Yes	○ No	
Name of Insurance Company			
Address			
Phone			
Contact			
Do you have/accept modified duty?	○ Yes	○ No	
Drug Screens required all Injuries?	○ Yes	○ No	

Record Distribution

Name of person to receive results:				
To be notified by:	○ Fax	○ Phone	○ Email	
Chain of Custody	○ Will bring with them	○ We have in our files		○ Other
Notes re: Chain of custody				

Services Requested

Physicals	☐ DOT	☐ Non-DOT	☐ None	
Drug Screens	☐ DOT	☐ Non-DOT	☐ None	
IF non-DOT	☐ 5-panel	☐ 9-panel	☐ 10-panel	
Lab Name	○ Alere	○ Lab 1	○ Other	
Specimin Handling ONLY	○ Yes	○ No		
Audiometry	○ Yes	○ No		
Spirometry	○ Yes	○ No		
Alcohol Testing	○ BAT	○ Urine	○ Hair	○ By request, if needed
Post Offer Of Employment (POET)	○ Yes	○ No		
Have Job Descriptions?	○ Yes	○ No		

NOTE: The POET is a POST OFFER assessment to determine if candidate can perform essential job functions and CAN be used to rescind a job offer.

Other	○ Yes	○ No
Hepatitis B - Titer	○ Yes	○ No
Hepatitis B - Series of 3	○ Yes	○ No
TB / Tetanus	○ Yes	○ No
Tdap (Tetanus, Diphtheria & Pertussis)	○ Yes	○ No
Chest X-Ray	○ Yes	○ No
Flu Shots	○ Yes	○ No
Respirator Questionnaire	○ Yes	○ No
Respirator Fit Testing	○ Yes	○ No
Eye Exams	○ Yes	○ No
HIV Testing	○ Yes	○ No
After Hours Services (Additional Charge)	○ Yes	○ No

Other Services Requested

	○ Yes	○ No
	○ Yes	○ No
	○ Yes	○ No
	○ Yes	○ No
	○ Yes	○ No
	○ Yes	○ No
	○ Yes	○ No
	○ Yes	○ No