OPTUM®

Urgent care and occupational medicine clinic
Client protocol service agreement

Business name: _____

Phone: _____ – _____ – _____ Fax: _____ – _____ – _____

Contact: _____ Title: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Contact for treatment of work-related injuries

Name: _____ Title: _____

Phone: _____ – _____ – _____ Fax: _____ – _____ – _____ Secured: ☐ Yes ☐ No

Name: _____ Title: _____

Phone: _____ – _____ – _____ Fax: _____ – _____ – _____ Secured: ☐ Yes ☐ No

Do you require a post-accident drug test or breath alcohol test? ☐ Yes ☐ No

Insurance information (please fill out completely)

Work comp insurance carrier: _____ Policy Number: _____

Contact: _____ Phone: _____ – _____ – _____

Carrier address: _____

City: _____ State: _____ Zip: _____

Billing information (if different than insurance information)

Company: _____ Contact: _____

Phone: _____ – _____ – _____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____ / _____ / _____

Services and requirements

	DOT	Post offer	Physical abilities	Hazmat initial	Hazmat periodic	Respiratory initial	Respiratory periodic
Physical							

Drug testing

NIDA		
NonNIDA		
Collection only		
BAT		

Post-accident work-related drug testing

	NIDA	NonNIDA	BAT
Post-accident			
Random			
On request only			
For cause			

Other services

	Yes	No
Hepatitis B vaccine		
TB test		

Lab preference: _____

Hospital: _____

PT/rehab: _____

Case management: _____

Comments: _____

_____

Name of person completing this form: _____

Title: _____ Date: _____ / _____ / _____

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