CENTERS FOR OCCUPATIONAL HEALTH
THIS FORM IS TO BE SENT TO MARYANN FORE, DANIELLE KELLER, DONNA MAUTE

☐ **New Business**	☐ **Change of Account Information**
☐ **Any Change/Add to Protocol**	☐ **Change in Billing Information**

Employer Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Contact Name: _____ **Email:** _____**Extension:** _____

Billing Contact: _____ **Email:** _____ **Phone:** _____

Patient's Name: _____ **Social:** _____ - _____ - _____ **DOS:** _____

Type of Business: _____ **# of Employees:** _____

Clinic Utilized: ☐ **PC** ☐ **SH** ☐ **CCMC**

Visit Type: ☐ **Workers' Comp** ☐ **Drug Screen/Collect** ☐ **Other:** _____

Billing Information

Workers' Compensation Carrier: _____

c/o TPA: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Policy Number: _____ **Effective Date:** _____

Insurance for Non-WC Services: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Fax:** _____

Bill for: ☐ **DS Collections** ☐ **Exams/Physicals** ☐ **Other:** _____

Change in Protocol is: _____

This form completed by: _____ **Date:** _____

DO NOT TREAT NEW PATIENT WITHOUT COMPANY AUTHORIZATION & COMPLETION OF THIS FORM