CareNow Urgent Care

Date:

Company Information Form

Company Name		No. of Employees	
Company Address	City	State	Zip
Company Phone	Company Fax		
Contact Name	Contact Email		

Personnel Able to Authorize Visits	Phone
1.	
2.	
3.	
4.	
After-hours Contact	**Phone**
1.	
2.	

Accounts Payable Contact

Name

Phone

Email

Fax

Workers Compensation Insurance Carrier Information

Carrier Name		Carrier Phone	
Carrier Address	City	State	Zip
Policy #	Effective Date (if available)	Carrier Fax	
Special Instructions			

Reason for Visit

- ◯ On the Job Injury
- ◯ Pre-Employment Services
- ◯ Other: _____

Drug Screen with Injury? ◯ Yes ◯ No

Standard Drug Screens
- ◯ Standard 10-Panel
- ◯ Standard 5-Panel
- ◯ DOT Drug Screen

Instant Drug Screens
- ◯ Instant 10-Panel
- ◯ Instant 5-Panel

Other Services
- ◯ Breath Alcohol Test
- ◯ DOT Physical
- ◯ Basic Occupational Physical
- ◯ Other (please explain): _____

Collection Only Lab Name: _____

Results Reporting

Please specify your preference for ***drug screen results only***

◯ **Online** Name _____
Email _____

◯ **Fax** Contact Name _____
Number _____

Please specify your preference for receiving physicals, work, status reports, etc.

◯ **Mail** _____

◯ **Fax** _____

◯ **Email** _____

Thank you for choosing CareNow as your occupational healthcare provider.
Please fax completed form to **844-226-1336**, ATTN: OccMed Team **or** email to **CareNowOccMed@HCAHealthcare.com**