



OCCUPATIONAL HEALTH SERVICES
AUTHORIZATION FOR WORK RELATED INJURY CARE

INJURY CARE LOCATIONS AND SERVICE HOURS
Sparrow Occupational Health Services
Sparrow Urgent Care (after-hours injury care)
Sparrow Hospital Emergency Room

EMPLOYEE INFORMATION:

Patient's Name: Date of Birth:

Authorizing Company: Social Security #:

INJURY INFORMATION:

Head Injuries that are accompanied by any of the following symptoms should be sent directly to the Sparrow Emergency Department: Nausea, Vomiting, Dizziness, Loss of Consciousness, Blurred Vision

Date of Injury: Date Injury Reported to Employer:

Description of Injury:

POST-ACCIDENT DRUG AND ALCOHOL TESTING (Photo Identification Required)

Breath Alcohol Testing (not available at Urgent Care (UC) Locations):

- Non-DOT Breath Alcohol Test
DOT Breath Alcohol Test

Lab Based Urine Drug Test:

- DOT Urine Drug Screen
Urine Drug Screen (Non-DOT)
Urine Drug Screen Collection Only
Other/Special Instructions:

Rapid Urine Drug Tests (not available at UC Locations):

- 5 Panel Rapid
11 Panel Rapid
Nicotine Rapid

I request and authorize the above-named employee to receive injury care from Sparrow Health Services. I further understand that my company will be financially responsible for any and all authorized services in the event my workers compensation insurance carrier denies the charges for any reason.

Supervisor Signature:

Printed Name: Date:

Contact Phone Number: Contact Email:



SPARROW OCCUPATIONAL HEALTH SERVICES AUTHORIZATION FOR SERVICES

<input type="checkbox"/> Sparrow Occupational Health Services Medical Arts Building 1322 E. Michigan Ave, Suite 101 Phone: 517-364-3900, Option 1 7am – 5pm, Monday through Friday
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<input type="checkbox"/> Sparrow St. Lawrence Emergency Department 1210 West Saginaw 5pm – 7am, Monday through Friday 24 hours Sat/Sun/Holidays
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Occupational Health Services takes the last Drug/Alcohol Test at 4:30pm.

Please have your employee here prior to 4:30 pm to ensure that there is enough time to complete the testing process.

SECTION 1: AUTHORIZING COMPANY

Company Name or Temp Agency:			
Street Address:	City:	State:	Zip
Services Authorized By (printed name):		Phone:	
Signature of Authorizing Person:		Date:	

SECTION 2: BILLING INFORMATION

Please indicate one: <input type="checkbox"/> Bill to my company (Skip to Patient Information) <input type="checkbox"/> Bill to my WC Carrier			
Workers Compensation Carrier:		WC Contact Name:	
Street Address:	City:	State:	Zip
Phone:		WC Claim No. (if known):	

SECTION 3: PATIENT INFORMATION

Employee Name:	
Social Security No:	Date of Birth:

SECTION 4: SERVICES AUTHORIZED

INJURY CARE (Appointments are required for injuries over 24 hours old)		
<input type="checkbox"/> Injury Care	Nature of Injury:	Date of Injury:
Time of Injury:	First Aid Treatment:	Substance Abuse Testing with Injury Care? <input type="checkbox"/> Yes <input type="checkbox"/> No

SUBSTANCE ABUSE TESTING (MUST BRING VALID PICTURE ID WITH YOU)

REASON FOR DRUG/ALCOHOL TESTING:					
<input type="checkbox"/> Reasonable Suspicion	<input type="checkbox"/> Pre-placement <input type="checkbox"/> Return to Duty	<input type="checkbox"/> Random Follow-Up <input type="checkbox"/> Post-Accident Other _____			
<input type="checkbox"/> Breath Alcohol Testing (please indicate one): <input type="checkbox"/> DOT Regulated <input type="checkbox"/> Non-DOT	<input type="checkbox"/> Specimen Collection Only	<input type="checkbox"/> Employee brings CCF	<input type="checkbox"/> CCF on file at Sparrow OHS		
	<input type="checkbox"/> Urine Drug Screen:	<input type="checkbox"/> DOT	<input type="checkbox"/> Non-DOT		
	If Non-DOT indicate Panel:	<input type="checkbox"/> 5 Panel	<input type="checkbox"/> 6 Panel	<input type="checkbox"/> 10 Panel	Other _____
	Instant Drug Test Panel:	<input type="checkbox"/> 5 Panel	<input type="checkbox"/> 12 Panel		
	<input type="checkbox"/> Hair Drug Test				
<input type="checkbox"/> Oral Swab Drug Test					

EMPLOYMENT PHYSICAL EXAMINATIONS (Appointments are required)

<input type="checkbox"/> Pre-Placement Physical	<input type="checkbox"/> Material Handling Capacity Test	<input type="checkbox"/> TB Skin Test
<input type="checkbox"/> Annual Physical	<input type="checkbox"/> Chest X-ray for Positive PPD	<input type="checkbox"/> Audiogram
<input type="checkbox"/> DOT Physical <input type="checkbox"/> Initial <input type="checkbox"/> Recertification	<input type="checkbox"/> Respirator Fit Testing	<input type="checkbox"/> Vaccination Assessment
<input type="checkbox"/> Fitness for Duty Exam	<input type="checkbox"/> Other:	
Surveillance Exam, Type of Surveillance: _____		
<input type="checkbox"/> Initial	<input type="checkbox"/> Periodic	<input type="checkbox"/> Post Exposure
<input type="checkbox"/> Exit		

SECTION 5: INSTRUCTIONS FOR PATIENT

- Please give 24 hours notice if you are unable to keep your appointment by calling 517-364-3900. A Late Cancellation/No Show Fee will be assessed if you miss your appointment without giving proper notice.*
- Please bring eyeglasses, contact lenses, or hearing aids to your physical exam appointment
- Please do not bring small children to your appointment unless you bring someone who can care for them while you are being treated. There are areas of the clinic where you may not bring children for their own safety.
- If you are under 18 years of age you will need a parent or legal guardian to sign our Consent Form prior to your treatment.*
- DOT/CDL EXAMINEES Please bring any and all relevant medical information with you to your appointment (example Hemoglobin A1C Results, CPAP Report, Current Medication List)



BILLING POLICIES

<u>REMIT PAYMENT TO:</u> SPARROW OCCUPATIONAL HEALTH SERVICES PO BOX 15158 LANSING, MI 48901	<u>CLINIC ADDRESS:</u> SPARROW OCCUPATIONAL HEALTH SERVICES 1322 EAST MICHIGAN AVENUE, SUITE 101 LANSING, MI 48912
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General Information

- Please send an Authorization Report Form with the patient to be treated or fax it to our office at (517) 364-3914. You may download one of our forms at www.sparrow.org/occupationalhealth or use your company's form.
- Occupational Health Services will be happy to treat injured workers at the time of injury; however it is imperative that the employer file a claim immediately with their Workers Compensation Insurance Carrier for prompt payment to be received. **Any visits initially authorized by an employer but later denied by the insurance carrier will become the employer's responsibility to pay.**
- Occupational Health Service's physicians **do not participate** with private insurance carriers (e.g. BCBS, PHP, BCN, SPHN). We provide services to injured workers and do not obtain private insurance information from the patient. Occupational Health Services billing office can submit a claim to either your company directly or to your workers compensation insurance carrier. However, if a claim remains unpaid after two submissions to your WC insurance carrier the charges will become the authorizing employer's responsibility to pay. Upon receipt of the invoice you should make payment to Occupational Health for the services and, if applicable, submit the claim to your insurance company for reimbursement.
- Occupational Health Services mail statements on a monthly basis. Payment is due upon receipt of your statement. Please make checks payable to **Occupational Health Services** and include the invoice number on your check.
- **Accounts with balances that have aged 90 days without payment will be transferred to a collection agency for processing.** If you are receiving past due statements and feel that there may be an error please contact our office and discuss your account with a Billing Specialist. You may contact our office by phone at 517-364-3900, Option #2 or visit www.sparrow.org/occupationalhealth/billing.asp to contact us by email.

Payment Options

- Occupational Health Services accepts payments through the mail in the form of check, money order, or credit card. We are also able to take credit card payments over the phone by calling our billing office at (517) 517-364-3900, Option #2. Please make check or money order payments out to Occupational Health Services and include the invoice number on your check. **Cash payment should be made in person.** Cash payments can be made at the Occupational Health Clinic. Invoices are mailed monthly and payment is due upon receipt of your statement.