Memorial Healthcare

Occupational Health
Dr. Carol Vorenkamp
100 Health Park Dr., Ste. 101
Owosso, MI 48867
Phone: 989-729-2265
Fax: 989-729-4050

Memorial Diagnostic Center
100 Health Park Drive
Owosso, MI 48867
Phone: 989-725-8847
Fax: 989-725-9958

Memorial Healthcare Main Lab
826 W. King Street
Owosso, MI 48867
Phone: 989-720-2273, ext. 3411
Fax: 989-723-5322

BILLING AUTHORIZATION

PLEASE PROVIDE SERVICES FOR THE FOLLOWING INDIVIDUAL

Name of Employee:_____ DOB:_____

Name of Company:_____ WC Carrier: Gallagher Bassett

Address:_____ Address: PO BOX 2831

_____ CLINTON, IA 52733-2831

Company Phone:_____ ext_____ Phone: 517.351.3100

Date of Injury:_____ Job Title:_____

Reason for Visit:_____

Lab / Drug Screening Required: ☐ MHC QT-6 Panel ☒ MHC QT-11 Panel ☐ DSCORPC
☒ Breath Alcohol ☐ NIDA 5 DOT ☐ NIDA 5 Non-DOT
☐ MHC 5 Panel

Random: ☐ Reasonable Suspicion: ☐ Post Accident: ☒ Return to Duty: ☐ Follow-up: ☐

Drug Screen Only: ☐ Other:_____

Type of Treatment / Testing Authorized: ☐ Hearing ☐ Vision ☐ FIT Test ☐ TB Test

_____

Specify DOT Agency: ☐ HHS ☐ NRC ☐ DOT

Employment Physical: ☐ WC: ☐

Supervisor's Signature: Anna Allars Date:_____

Supervisor's or Human Resource Manager Contact Phone Number: 419.893.5400 x2104

Secure / Confidential Business FAX for Result Submissions: _____

RELEASE OF RECORDS

I hereby authorize_____, its physicians and agents, to release any complete medical record that may contain treatment for physical, psychiatric, and/or emotional illness including drug or alcohol abuse and information which may be contained in my patient records, pertaining to serious communicable diseases as defined by the Department of Public Health Rules including Hepatitis B, Venereal Disease, and Tuberculosis or infections of Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC)k, to my employer, Memorial Healthcare, Memorial Medical Associates, Memorial Healthcare Laboratory Services, and to any third party administrator/reviewer responsible for payment.

Employee Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Memorial Healthcare | Family Medicine/ Occupational Medicine

TO: Date: 2022

Company/Department: _____

Attention: _____

Address: _____

Phone Number: _____ Fax Number: _____

FROM: Memorial Healthcare Family Medicine/Occupational Medicine
100 Health Park Drive, Suite 101
Owosso, MI 48867 Carol Vorenkamp, DO
Phone: 989.729.2255
Fax: 989.729.4050

Number of pages including cover sheet in this transmission: _____

Message:

New Billing Auth. Please toss old Auth. When filling out Please make sure everything is filled out to avoid any delays.

Please Use!!

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