fastpacehealth

Employer Authorization Form

Patient must present Photo ID and Authorization Form at time of service

SECTION I:	**PATIENT INFORMATION**		
Last Name		First Name	
Date of Birth (MM/DD/YYYY)		SSAN	
SECTION II:	**COMPANY INFORMATION**		
Employer Name	JEFFERSON COUNTY GOVERNMENT	Fast Pace Account #	FPTN 35254
Primary Contact	Jeannine Knowlan	Phone Number	865-397-4922
Address City, State, ZIP	1222 GAY STR. PO BOX 710, Dandridge TN 37725	Email	jknowlan@jeffersoncountytn.gov

SECTION III: AUTHORIZED SERVICES (check all that apply for this visit)

☐ Urine Collection Only (80306)	☐ Federal / DOT (80306)	☐ 10 Panel eScreen Instant (eCup+)(80306)
☐ Observed Fee (99211OF)	☐ 10 Panel Lab (80306)	☐ TN Drug Free (80306)
☐ DOT Physical (99455)	☐ Non-DOT / Pre-Employment Physical (99455ND)	☐ Breath Alcohol Test (82075)
☐ Flu Vaccine (90686)	☐ Immunization Administration (90471)	☐ Fit for Duty Physical (97161)
☐ Tetanus, (Tdap) (90715)	☐ Hep B Titer (86706)	☐ Tetanus, Diphtheria (90714)
☐ Hep A Titer (86708)	☐ Hepatitis C Panel (87522)	☐ Hep C Titer (86803)
☐ Hepatitis Panel 4 (80074)	☐ TB Gold/Blood (86480)	☐ MMR Titer (86735, 86765, 86762)
☐ EKG (93000)	☐ Venipuncture (36415)	☐ PPD Questionnaire (86580Q)
☐ Visual Acuity Test – Snellen (99173)	☐ Color Vision Exam – Ishihara	☐ Varicella Titer (86787)
☐ Pure Tone Audiometry (92551)	☐ Lift test (97161)	☐ Chest X-ray 1 or 2 view (71046)

Employer is a participant of the Federal Drug Free Work Force program: ☐ Yes (Program requires Lab Based UDS) ☐ No

☐ Pre-Employment	☐ Reasonable Suspicion	☐ Random
☐ Post-Accident/Post Injury	☐ DOT Return to Work (Observed-Federal COC)	

SECTION IV: WORKERS' COMPENSATION

☐ Workers' Compensation Injury Treatment ☐ Workers Comp Initial Visit Only

Date of Injury:_____ Type of Injury: _____

W/C Authorization Number: _____

Where are claims to be filed? ☐ Bill Employer ☐ Insurance Carrier

W/C Carrier Name: Safety Engineering and Claims Management

W/C Carrier Address: _____

W/C Carrier Phone:_____ W/C Carrier Fax:_____Policy Number:_____

SECTION V: CUSTOMER ACKNOWLEDGEMENT

EMPLOYER: I hereby authorize the medical provider to treat the named employee above. I acknowledge that all services will be paid for in full by the listed company. Unless stated otherwise in Section IV, this authorization covers both the initial and necessary all follow-up visits. By signing below, I certify the correctness of all information and consent to the stipulated terms.

X_____ _____ _____ _____

Employer Authorized Signature (Required) **Date** **Employer Printed Name (Required)** **Title**