Optum

Visit Authorization Form

1. EMPLOYEE INFORMATION

Name: _____ **DOB:** _____

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

Phone #: _____ **Scheduled Date(s) & Times**: _____

2. EMPLOYER / COMPANY INFORMATION

Company Name: _____ **eScreen Acct #** ***(if applicable)*****:** _____

Address: _____ **City**: _____ **State**: ____ **Zip**: _____

Services Authorized By: _____
(Name & Title, please print)

Signature: _____ **Phone #**: _____

DER/Company contact for results and/or physician call: _____

E-mail: _____

Phone #: _____ **Ext**: _____ **Secure Fax**: _____

BILLING ADDRESS *(only if different than above)*:

TPA Name *(if applicable)*: _____

Address: _____ **City**: _____ **State**: ____ **Zip**: _____

Phone #: _____ **Ext**: _____ **Secure Fax**: _____

3. WORKERS COMPENSATION & NO-FAULT INSURANCE VERIFICATION INFORMATION

Employee Full Social Security #: _____

Workers Compensation Insurance Carrier: _____

No-Fault Insurance Carrier: _____

Address: _____ **City**: _____ **State**: ___ **Zip**: _____

Carrier Phone #: _____ **Ext**: _____ **Secure Fax**: _____

CLAIM #: _____ **Date of Injury:** _____

Site/Type/Limb Injured: _____

Adjuster Name: _____ **Adjuster Phone #**: _____

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Visit Authorization Form
(continued)

EMPLOYEE INFORMATION

Employee Name: _____ **Employee DOB**: _____

STEP ONE *(if applicable – for UDS)*

Check the following:

- ☐ Using eScreen Lab & MRO
- ☐ Using Company Provided Lab & MRO
  (Please provide CCF, including preferred panel)

STEP TWO *(UDS and BAT only)*

Reason for testing:

- ☐ Pre-employment
- ☐ Post-accident
- ☐ Random
- ☐ Reasonable Suspicion
- ☐ Return-to-duty
- ☐ Follow-up

(DOT Return-to-duty & Follow-up testing **MUST BE OBSERVED**)

STEP THREE: Please select all services to be performed

PHOTO ID IS REQUIRED

☐ Worker's Compensation Injury Treatment

DOT Drug/Alcohol Testing:	☐ DOT Urine Drug Screen (DOT 5-panel send-out) — Is this an observed collection? _____ (Please notify center of an observed collection before employee arrival.) ☐ DOT Breath Alcohol Test
Non-DOT Drug/Alcohol Testing:	Non-DOT Urine Drug Screen: — Is this an observed collection? _____ (Please notify center of an observed collection before employee arrival.) ☐ Rapid 5-drug panel ☐ Rapid 10-drug panel ☐ Send-out to Lab *(please provide CCF if using Company Lab)* ☐ Non-DOT Breath Alcohol Test
Hair Drug Testing:	☐ Hair Drug Testing Reference Lab: _____ Panel: _____
Physical Examination:	☐ DOT Physical ☐ Non-DOT Physical (Standard pre-employment)
Bloodwork:	Titers: ☐ Hep A ☐ Hep B ☐ MMR ☐ QuantiFERON-TB Gold Plus
Other Services:	TB Skin Test (PPD): ☐ 1 Step ☐ 2 Step ☐ Chest X-Ray (if needed for positive PPD or if employee previous had BCG Vaccine) Vaccine: ☐ Flu ☐ Hep A ☐ Hep B ☐ MMR