MARQUE MEDICAL

Please email form to: occmed@marquemedical.com or fax to: 949-579-2906

EMPLOYER INSTRUCTIONS FOR WORKPLACE MEDICAL TREATMENT

Company Information

Company Name: _____
Contact Name: _____
Address: _____
Address 1: _____
City: _____
State: _____
Zip Code: _____

Additional Contact: _____

Contact Information

	Full Name	Phone Number	Fax Number	Email	Can receive employee reports? If yes, list type.
Authorized Primary:					
Authorized Other					

Billing Information

Workers' Comp Carrier Information

W/C Bill To (TPA or Carrier Name):
W/C Carrier Name: _____
Policy Number: _____
Effective Date: _____
Contact Name: _____
Contact Phone: _____
Contact Fax: _____
Contact Email: _____

Direct Bill & Employer Paid Services / "EPS" Information

Billing Contact: _____
Billing Address: _____
Billing Address 2: _____
City: _____
State: _____
Zip Code: _____
Phone/Email: _____

Instructions

At times it may be difficult to obtain a written treatment authorization from the employer.

Do we have your permission to treat your employee without a written authorization? ☐ YES ☐ NO

Who is the designated person for authorization for treatment? _____

Additional Comments:

Additional Information

Are we to provide Employer Paid Services/Non Work Comp Services? ☐ YES ☐ NO

Are we to provide Injury Care (Work Comp)? ☐ YES ☐ NO

Are we to provide Employer Paid Wellness Services (such as vaccines and immunizations)? ☐ YES ☐ NO

If the above answer is yes, who is the contact for Wellness services? _____

Wellness Services Contact Phone _____

Wellness Services Contact Email _____

What is the primary Marque Facility/Location(s) _____

Injury Care (W/C) Information

Bill Employer for First Aid? (please note that DFR will be sent to carrier) ☐ YES ☐ NO

Does Employer have modified Work Available? ☐ YES ☐ NO

Does Employer require Post Injury Drug or Alcohol Screens? ☐ YES ☐ NO

If above answer was yes, please specify type _____

Protocol Summary - Please provide addendums to specific areas above if required