



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		Fast Pace Account #	
Primary Contact		Phone Number	
Address City, State, ZIP		Email	
SECTION III: AUTHORIZED SERVICES (check all that apply for this visit)			
<input type="checkbox"/> Urine Collection Only (80306)	<input type="checkbox"/> 10 Panel Non-Federal COC (80306)	10 Panel Federal DOT (80306)	
<input type="checkbox"/> Observed Fee (992110F)	<input type="checkbox"/> 12 Panel In-House Drug Screen (80305)	Breath Alcohol Test (82075)	
<input type="checkbox"/> DOT Physical (99455)	<input type="checkbox"/> Pre-Employment Physical (99455ND)	Fit for Duty Physical (97161)	
<input type="checkbox"/> Flu Vaccine (90686)	<input type="checkbox"/> Hep B Vaccine (90746)	Tetanus, Diphtheria (90714)	
<input type="checkbox"/> Tetanus, (Tdap) (90715)	<input type="checkbox"/> Immunization Administration (90471)	Hep C Titer (86803)	
<input type="checkbox"/> Hep A Titer (86708)	<input type="checkbox"/> Hep B Titer (86706)	MMR Titer (86735, 86765, 86762)	
<input type="checkbox"/> Hepatitis Panel 4 (80074)	<input type="checkbox"/> Hepatitis C Panel (87522)	PPD Questionnaire (86580Q)	
<input type="checkbox"/> PPD (TB Test) (86580)	<input type="checkbox"/> PPD/TB Gold/Blood (86480)	Varicella Titer (86787)	
<input type="checkbox"/> EKG (93000)	<input type="checkbox"/> Venipuncture (36415)	Chest X-ray 1 or 2 view (71046)	
<input type="checkbox"/> Visual Acuity Test – Snellen (99173)	<input type="checkbox"/> Color Vision Exam – Ishihara (92283BCS)	Lift test (97161)	
<input type="checkbox"/> Pure Tone Audiometry (92551)	Non-DOT Physicals		
Employer is a participant of the Federal Drug Free Work Force program: <input type="checkbox"/> Yes (Program requires Lab Based UDS) <input type="checkbox"/> No			
<input type="checkbox"/> Pre-Employment	<input type="checkbox"/> Reasonable Suspicion	<input type="checkbox"/> Random	
<input type="checkbox"/> Post-Accident/Post Injury	<input type="checkbox"/> DOT Return to Work (Observed-Federal COC)		
SECTION IV: WORKERS' COMPENSATION			
<input type="checkbox"/> Workers' Compensation Injury Treatment			
Date of Injury: _____ Type of Injury: _____			
W/C Authorization Number: _____			
Where are claims to be filed? <input type="checkbox"/> Bill Employer <input type="checkbox"/> Insurance Carrier			
W/C Carrier Name: _____			
W/C Carrier Address: _____			
W/C Carrier Phone: _____ W/C Carrier Fax: _____ Policy Number: _____			
SECTION V: CUSTOMER ACKNOWLEDGEMENT			
EMPLOYER: This certifies that the above information is correct. I authorize the medical provider to provide medical treatment to the employee named above. I also understand that the services provided will be paid in full by the company listed above and authorized by my signature.			
X _____			
Employer Authorized Signature (Required)	Date	Employer Printed Name (Required)	Title