Adventist Health Castle

OCCUPATIONAL MEDICINE COMPANY PROFILE

P: 808.456.CARE (2273) | E: occmed@ucarehi.com | W: www.ucarehi.com

LOCATION OF INTEREST: ❒ KAPOLEI ❒ KAILUA ❒ PEARL CITY ❒ WAIKIKI
Please select all that apply

Company Name:_____ **Contact Name:**_____

Company Address:_____
Street Address *City/State/Zip*

Phone Number:_____ **Fax Number:**_____

Authorization List:_____
**Who is authorized to call on behalf of your employee or who are we allowed to speak to regarding results?*

BILLING INFORMATION

Do you want your statement printed? ❒ Yes ❒ No

How would you like your statement printed? ❒ Summary (All employees on a single page)
❒ Detailed (Each employee on a single page)
❒ Both

Would you like to include SSN on statement? ❒ Yes ❒ No

WORKERS COMPENSATION/WORK-RELATED INJURY INFORMATION

Is your company self-insured? ❒ Yes ❒ No
**If no, please fill out the following information*

Name of WC Insurance Company:_____

Address:_____
Street Address *City/State/Zip*

Contact Name(s):_____

Contact Number:_____ Fax Number:_____

****We will notify you if your employees' injury requires **First Aid Treatment vs. Workers Compensation** (OSHA Recordable).*
*First Aid Treatment is billed directly to the company using our Fee for Service rates and not to the insurance carrier****

EMPLOYEE PAID SERVICES (EPS) INFORMATION

How would you like to pay for the services? ❒ Employee ❒ Employer ❒ Company HR ❒ Company Headquarters
** If address is same as company address above, you may leave the mailing section blank.*

Mailing Address:_____
Street Address *City/State/Zip*

Contact Name:_____ Contact Number:_____

Payments will be made attention to:_____

***HOW WOULD YOU LIKE US TO SEND THE RESULTS (PLEASE SELECT ONE)?**	❒ Fax	❒ Mail	❒ Email	

*Please complete if you selected **mail**:*

Mailing Address:_____
Street Address *City/State/Zip*

*Please complete if you selected **email**:*

Email:_____ Email password:_____
To access results, please provide us with a customized **six-character password.*

*Please complete if you selected **fax**:*

Fax Number:_____ Attention to:_____

***REVISE DATE:** 10/20/2020*

EMPLOYER PAID SERVICES (EPS) SERVICES REQUESTED

Company Name:_____

First Aid	❑ Yes	❑ No	**Please note, if the injury does not meet First Aid guidelines, we will proceed to care for the employee based on the injury and this may become a Workers Compensation Claim*	
PHYSICALS				
Standard Physicals	❑ Yes	❑ No	*Please select all that apply:*	❑ Basic ❑ Pre-Employment ❑ Return-to-Work/Fit-for-Duty
DOT/CDL Physicals *SCHEDULING AVAILABLE	❑ Yes	❑ No	*Exclusivity Tiers of Care (Updated July 2019)*	❑ DOT/CDL, standard - *$125*
***Tiers of Care are EXCLUSIVITY Rates:**, Your employees MUST come in with forms already completed and medical related conditions must meet the requirements of our checklist prior to coming in. Tiers are based on the complexity of the visit. Forms can be found ONLINE at our website: www.ucarehi.com.*				
LAB SERVICES				
Drug Screening	❑ Yes	❑ No	*Please select all that apply:*	❑ Non-DOT Panel 5 ❑ Non-DOT Panel 10 ❑ DOT Panel 5 ❑ Instant Panel 5 ❑ Instant Panel 12 ❑ DOT Drug Collection Only ***Chain of Custody form must be LabCorp**
Drug Testing MRO Services	❑ Use Urgent Care HI MRO ❑ Provide own MRO ***Chain of Custody Form must be LabCorp*** Name of MRO:_____ Address of MRO:_____ *Street Address* *City/State/Zip* Phone Number:_____Fax Number:_____			
Immunizations	❑ Yes	❑ No	❑ Tetanus ❑ Flu ❑ MMR ❑ Hepatitis B Series (Series of 3 shots) ❑ Hepatitis A (Series of 2 shots)	
Other Tests	❑ Yes	❑ No	❑ Covid-19 RNA by PCR (Nasal Swab) ❑ MMR Titer ❑ Hep B Titer ❑ Varicella Titer ❑ Covid-19 Rapid Antigen Test (Nasal Swab) ❑ Covid-19 Antibody (Blood Test) ❑ Others (please specify) _____	
PROCEDURES				
Procedures	❑ Yes	❑ No	❑ EKG ❑ Spirometry	
TB Clearance	❑ Yes	❑ No	❑ Risk Assessment ❑ Skin Test ❑ Chest Xray	
Respirator	❑ Yes	❑ No	❑ Respirator Clearance ***Comes with Clearance Card*** *(*Will proceed to Respirator Physical Exam if employee fails Respirator Questionnaire)* ❑ Respirator Physical Exam ❑ Qualitative Respirator Fit Test *(*Employee must bring their own mask and copy of their clearance card)*	
Alcohol Testing	❑ Yes	❑ No	❑ DOT	

Other Special Instructions: **Please feel free to attach any additional documents for review*

Upon completing, our Occupational Medicine Specialist, Maria Rica Cunanan will reach out to you.
***Phone:** 808.521.2273 | **Email:** occmed@ucarehi.com*