

# New Client Set Up

Please provide TPA Information, company specific form(s), CCF's/ATF's for Collections, Worker's Compensation Carrier info you would like on file, and/or applicable Protocols.

Get completed visit documents & results on our Portal

Company Name: \_\_\_\_\_ P: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Email: \_\_\_\_\_ P: \_\_\_\_\_

Additional Company Contact(s)/info. if applicable: \_\_\_\_\_

Company Type:  Non-DOT  FAA  PHMSA  FMCSA  Non-DOT

## Billing Information (if different than above)

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

AP Contact Name: \_\_\_\_\_ Email: \_\_\_\_\_ P: \_\_\_\_\_

Work Comp Carrier Name: \_\_\_\_\_ P: \_\_\_\_\_

Claims Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Policy #: \_\_\_\_\_ Adjuster Name/ contact info: \_\_\_\_\_

**Drug Screen/ Breath Alcohol:**  Random Consortium Pool  DOT Urine  DOT Breath Alcohol  
 Collection Only (must provide CCF) Non-DOT:  Urine  Instant  Hair  Saliva  Breath Alcohol

**Physical:**  DOT Physical  Basic Physical  Essential Functions Test (EFT)  Physical w/ EFT  
 Fit for Duty (Return to work)  Personal Capacity Profile (PCP) Level: \_\_\_\_\_

**Respiratory:** TB Test:  Skin  Blood  Chest X-Ray  Respiratory Physical  PFT/Spirometry  MEQ and/or Fit Test

**Work Comp:**  Bill Company Direct for Visit  Bill Work Comp Carrier

**Audio/Vision:**  Audiogram  Basic Vision (Snellen)  Titmus Vision  Color Vision  Depth Perception

**Other:**  Hep B Series  Hep B Titer  Tetanus Vaccine  Blood Testing  \_\_\_\_\_

Authorized Company Representative: \_\_\_\_\_ Date: \_\_\_\_\_