MedCare Specialists
A Division of FamilyCare Specialists
Covenant Medical Group

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Knoxville, TN 37909
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MedCare Client Information

THIS FORM MUST BE RECEIVED AT OUR OFFICE PRIOR TO PATIENT RECORDS BEING RELEASED.

******* Existing Client: Please update company information for our records ******

Company Name: _____
Address: _____
City: _____State: _____ ZIP: _____
Phone: _____Fax: _____
Contact Person: _____
E-Mail: _____DER: _____

***Worker's Compensation Claims Information* (MANDATORY BY TN DEPT. OR LABOR)**
Workers Compensation Claims Carrier: _____
Address: _____
City: _____State: _____ZIP: _____
Contact person / Case manager: _____
Contact phone number: (_____)_____

What services would you like to utilize? (Check all that apply)
Physicals:
Pre-Employment: _____ Random: _____ DOT: ____ DOT w/Lumbar: _____ Respiratory: ____

Drug Screens:
10 Panel: _____ 5 Panel: _____ 5 Panel Instant: _____ Collection Only: _____

- If we collect only, who is your designated laboratory?
  _____
- Who will be billed for collections only? Employer _____ Designated Lab? _____

- Who is your company Designated Employer Representative (DER)?
  _____ Email: _____
- Will the patient bring the Chain of Custody and/or lab materials, or should we supply them at the time of testing?
  Employee will bring supplies: _____ MedCare to provide supplies: _____

- If we do instant testing, do you want your employee to be given a copy of the test to return to you, or would you rather that we mail it?
  Employee: _____ Mail (results will be delayed during mailing time): _____

Workers Compensation

Are we currently listed as a provider on your workers compensation list (C-42 Panel)?
YES _____ NO _____

Who should we contact to receive authorization to treat a work related injury?
Name: _____ Phone Number: _____

Do you want the employee to return the work duty status sheets, or would you want them to be mailed? Employee _____ Mail _____

Do you want a post-accident drug screen performed on all work related injuries?
YES _____ NO _____
(If "yes", please make sure to complete the drug screen section of this form on page 1.)

Would you like a post-accident breath alcohol test (BAT) done? YES _____ NO _____

Are you currently a member of Drug Free Tennessee? YES _____ NO _____