

Employer Profile Form

New Company Information & Updates

In order to use our clinics for the treatment of Work Related Injuries and Occupational Services, you must establish an account with Texas MedClinic. By establishing an account, our clinics will have access to your company's specific protocol and the invoices for services can be billed to your company.

To establish an account with Texas MedClinic, follow the instructions below:

- Fill out the Employer Profile forms
- Once completed please email or fax to our Business Development & Marketing Department
Email: businessdevelopment@texasmedclinic.com or Fax: 210-471-0217
- Allow 1-2 business days for us to complete the set up of your account
- A Business Development & Marketing Representative will contact you to inform you that new account/updates have been put into our system.

If you have any questions please contact the Business Development/Marketing Department

San Antonio: 210.349.5577 ext 8521

Austin: 512.486.6110

**Thank you for choosing Texas MedClinic
to handle your Occupational Healthcare needs.**



texasmedclinic.com

EMPLOYER PROFILE FORM

COMPANY CONTACT INFORMATION

Company has multiple locations (Please provide a list of locations)

COMPANY NAME: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____

Email: _____

Company Industry/Trade: _____ Number of Employees: _____

COMPANY CONTACTS

Main Contact & Portal Administrator	Texas MedClinic Employer Portal
Name: _____	You will receive an email with information regarding your username, password, and user agreements. You will need to login and access your new Employer Portal account to receive our reporting results. Once you have logged on and changed your password you will be able to assign other users within your company to your Portal. For security reasons you are the only administrator and will be the only one that can add or remove users. Once you have assigned a user, the user will receive an email with a link and they will have to sign in as you did to access the employer portal. Until they do this they will not be able to access the portal. All of the company's results will be reported ONLY to your Employer Portal so it is important that you do not delay in setting up access. The Employer Portal can now be viewed on any electronic device offering more freedom to its users.
Phone: _____ Ext: _____	
Fax: _____	
Email: _____	
<u>Treatment Authorization & Employment Verification</u> <input type="checkbox"/> Authorize Services for <input type="checkbox"/> WRI <input type="checkbox"/> OCC <input type="checkbox"/> Both <input type="checkbox"/> After Hours Contact <input type="checkbox"/> WRI <input type="checkbox"/> OCC <input type="checkbox"/> Both Cell: _____	
<i>If at any time you are experiencing issues, do not hesitate to contact us for assistance at 210.349.5577 ext. 8521.</i>	

Remove Contact Name (s): _____

Additional Contact	Portal Authorized User <input type="checkbox"/>	<u>Treatment Authorization & Employment Verification</u> <input type="checkbox"/> Authorize Services for <input type="checkbox"/> WRI <input type="checkbox"/> OCC <input type="checkbox"/> Both <input type="checkbox"/> After Hours Contact <input type="checkbox"/> WRI <input type="checkbox"/> OCC <input type="checkbox"/> Both Cell: _____
Name: _____		
Phone: _____ Ext: _____		
Fax: _____		
Email: _____		

Additional Contact	Portal Authorized User <input type="checkbox"/>	<u>Treatment Authorization & Employment Verification</u> <input type="checkbox"/> Authorize Services for <input type="checkbox"/> WRI <input type="checkbox"/> OCC <input type="checkbox"/> Both <input type="checkbox"/> After Hours Contact <input type="checkbox"/> WRI <input type="checkbox"/> OCC <input type="checkbox"/> Both Cell: _____
Name: _____		
Phone: _____ Ext: _____		
Fax: _____		
Email: _____		

OCCUPATIONAL SERVICES

Company Name: _____

OCCUPATIONAL SERVICES BILLING:

Name of consortium or third party administrator (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____

I do not use a consortium or third party administrator.

Billing Address (if different than physical address):

Address: _____

Occupational Billing Contact:

Name: _____

City/State: _____

Phone: _____ Ext: _____

Zip: _____

Email: _____

SERVICES:

Pre-Employment Drug Testing

- Hair Drug Test
- DOT
- 5 Panel Non-DOT
- 10 Panel Non-DOT
- 5 Panel Non-DOT, Expanded
- 10 Panel Non-DOT, Expanded
- 5 Panel Rapid
- 10 Panel Rapid

Random/For Cause Drug Testing

- Hair Follicle
- DOT
- 5 Panel Non-DOT
- 10 Panel Non-DOT
- 5 Panel Non-DOT, Expanded
- 10 Panel Non-DOT, Expanded
- 5 Panel Rapid
- 10 Panel Rapid

Breath Alcohol Testing

- Random
- For Cause

Physicals

- Post Offer Physical
- DOT Physical
- Respirator Physical
- Hazardous Waste Physical
- Asbestos Physical
- Silica Dust Exams (Includes: TB Test, Chest X-Ray, PFT & Physical)

Ancillary

- TB test
 - X-ray authorized for TB Test if needed
- Chest x-ray
- Hearing Test
- Vision
- PFT/Spirometry
- Respirator Fit Test
- Functional Ability Test

Immunizations

- Hepatitis A
- Hepatitis B
- Tdap
- MMR
- Varicella
- Flu Shot
- Titer: _____
- Other: _____

All Physicals will be performed using Texas MedClinic's forms unless otherwise indicated

WORK RELATED SERVICES

Company Name: _____

WORKERS' COMPENSATION BILLING:

Subscriber (Company has Workers Comp Insurance)

Name of Workers Comp Insurance: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

If you are a subscriber, are you in a Network? Yes No

Please indicate name of Network: _____

Non- Subscriber (Do not have Workers Comp insurance)

Billing Address (if different than physical address):

Address: _____

City/State: _____

Zip: _____

Workers Comp Billing Contact:

Name: _____

Phone: _____

Fax: _____

Email: _____

SERVICES:

Post Accident Drug Test

Required When requested

- Hair Follicle
- DOT
- 5 Panel Non-DOT
- 10 Panel Non-DOT
- 5 Panel Non-DOT, Expanded
- 10 Panel Non-DOT, Expanded
- 5 Panel Rapid
- 10 Panel Rapid

Breath Alcohol Tests

Post Accident

- Required
- When Requested

Please check all that apply

- Modified Duty Available
- Company is under OSHA 300 Log
- Supervisor will bring employee to clinic
- Company Specific Forms (please attach copy of form)