

Date \_\_\_\_\_  
Name of person completing this form \_\_\_\_\_

WRK# \_\_\_\_\_  
PT Acct# \_\_\_\_\_

### WORKERS' COMPENSATION ACCOUNT INFORMATION

<b>Company Name</b> _____
Mailing Address _____
Phone (     ) _____ Fax (     ) _____ W/C Contact _____
# of Employees (G'boro Area) _____ Email _____

<b>Company Headquarters/Main Office</b> _____
Address _____
Phone (     ) _____ Fax (     ) _____ W/C Contact _____

<b>Workers' Compensation Insurance Carrier</b> _____
Policy # _____ Effective Dates _____
Mailing Address _____
Phone (     ) _____ Fax (     ) _____
Contact Person _____ Contact's Phone (     ) _____

<b>Does your Company require post-accident drug testing?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> NIDA	<input type="checkbox"/> Non-NIDA
<b>Does your Company require post-accident alcohol testing?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Please indicate which type of test:</b>	<input type="checkbox"/> Blood	<input type="checkbox"/> Breath

**Where do you want us to send the Workers' Compensation bills?** (select one)

Company Address                       Company Headquarters                       Insurance Company

**Does your company or insurance carrier require pre-authorization for referrals?**     Yes                       No

**If yes, please give the contact name and phone number for pre-authorization:** \_\_\_\_\_  
\_\_\_\_\_

**Is there any additional information we should know about your workers' compensation coverage or account?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>For Office Use Only:</b>
Date Purple sent _____ Date entered in database _____ Initials _____