REDWOODS
A CRUM & FORSTER COMPANY

Designated Medical Provider Protocol

Identify Location of Nearest Providers
Name
Address
Phone / Fax / Email / Website

Insured's Information

Organization Name: _____

Phone: _____ Fax: _____

Contact: _____

Title: _____

Address: _____

City, State, Zip: _____

Email: _____

Current Number of Employees: _____

Type of Business:

☐ Corporate Office ☐ Local Office

Contacts for Injury Authorization and Questions

Name: _____

Title: _____

Phone: _____ Fax: _____

Is your fax secured (access only to those who have authority to view medical information)?

❑ Yes ❑ No

Alternate: _____

Title: _____ Phone: _____

Insurance Information

Work Comp Insurance Carrier: _____ Policy #: _____

Contact: _____

Phone: _____

Carrier Address: _____

City, State, Zip: _____

Work Comp Insurance Broker and Company (if applicable): _____

Corporate Health Services

Urine Drug and Breath Alcohol Testing Per Company's Policy

	DOT COLLECTION (Sent to Lab)	Sam 5 Non-NIDA (Sent to Lab)	Rapid Drug Screen (Same Day)	Breath Alcohol (Same Day)
Post-Accident *(check only if mandatory)*	❑	❑	❑	❑
Post-accident procedures are billed directly to the company, not to your Workers' Compensation Carrier.				
Pre-Employment	❑	❑	❑	❑
For Cause/Suspicion	❑	❑	❑	❑
Random	❑	❑	❑	❑
On Request Only	❑	❑	❑	❑

Do you have a written drug policy? ❑ Yes ❑ No Initial _____

Name of drug laboratory if different then healthcare provider designated lab: _____

MRO (Medical Review Officer) service to be performed by: _____

Other Services Requested

☐ DOT Physicals ☐ Pre-employment Physicals ☐ Annual Physicals

☐ Other: _____

Special protocols attached? ☐ Yes ☐ No

Contacts for Drug Screen Results

Name: _____ Title: _____

Phone: _____ Fax: _____

Is your fax secured (access only to those who have authority to view medical information)?

☐ Yes ☐ No

Alternate: _____

Title: _____ Phone: _____

Corporate Health Services Billing Instructions

☐ **Workers' Compensation Information**

Our organization has designated _____ as our designated provider for work related injuries. We agree to notify _____ of any changes in address, contact person or insurance carrier within 30 days of such change. We understand that _____ providers require claim numbers within ten days of first date of treatment. Initial _____

☐ **Corporate Health**

We agree to the corporate health services specified above and understand that prices for these services are established by the healthcare provider. Each provider of services will bill you for services provided at their location. Bills will be mailed to the individual specified in the Billing Instructions section of this agreement.

Signature: _____ Date: _____

Special Instructions

_____

_____