Central Occupational Medicine Providers
Comprehensive Industrial Case Management & Treatment Centers

Courtesy Transportation Available 24 Hours a Day / 7 days a week for 1st Injury Visit
Visit us at: https://www.comp-medicalgroup.com

EMPLOYER REGISTRATION PACKET

Company Code: __________

(Please email form to info@cenocc.com)

Company Name: ______________________ **Standard Industrial Classification (SIC) #** __________

Location Address: ______________________ City: __________ State: ______ Zip: ______

Type of Business: ______________________ Hours of Operation: __________ # of Employees: __________

Does your Company use Temp/Staffing Agency? ☐ YES ☐ NO If yes, which **Staffing Agency**? ______________________

Corporate Name (*if applicable*): ______________________

Corporate Address: ______________________ City: __________ State: ______ Zip: ______

INJURY CONTACT INFORMATION

Primary Contact Person: ______________________ ☐ With Location ☐ With Corporate Office

Email Address: ______________ Phone #: __________ CP #: __________ Fax: __________

Secondary Contact Person: ______________________ ☐ With Location ☐ With Corporate Office

Email Address: ______________ Phone #: __________ CP #: __________ Fax: __________

After Hours Contact Person: ______________________ ☐ With Location ☐ With Corporate Office

Email Address: ______________ Phone #: __________ CP #: __________ Fax: __________

PRE-EMPLOYMENT CONTACT INFORMATION

Primary Contact Person: ______________________ ☐ With Location ☐ With Corporate Office

Email Address: ______________ Phone #: __________ CP #: __________ Fax: __________

Secondary Contact Person: ______________________ ☐ With Location ☐ With Corporate Office

Email Address: ______________ Phone #: __________ CP #: __________ Fax: __________

WORKERS COMP INSURANCE CARRIER / CLAIMS ADMINISTRATOR / BILL REVIEWER INFORMATION

Is Company Self Insured? ☐ Yes ☐ No

**Company named above is assumed authorized and is responsible for payments to COMP. If not, please attach Certificate of Insurance and provide following information:

Insurance Carrier: ______________________ Policy #: __________ Expiration Date: __________

Mailing Address: ______________________ City: __________ State: ______ Zip: ______

Assigned Adjuster: ______________________ Phone #: __________ Fax: __________

Email Address: ______________

Please provide information below if applicable:

TPA / Claims Administrator: ______________________

Mailing Address: ______________________ City: __________ State: ______ Zip: ______

Assigned Adjuster: ______________________ Phone #: __________ Fax: __________

Email Address: ______________

Bill Reviewer: ______________________

Mailing Address: ______________________ City: __________ State: ______ Zip: ______

Assigned Bill Reviewer: ______________________ Phone #: __________ Fax: __________

Email Address: ______________

DRUG TEST INFORMATION – TPA OR LABORATORY USED (*if applicable*)

TPA: ______________________ **Laboratory Used:** ______________________

Attention/Send to: ______________________ Email Address: ______________ Fax: __________

Mailing Address: ______________________ City: __________ State: ______ Zip: ______

______________ **EMPLOYER'S AUTHORIZED SIGNATURE** ______________
*Print Name *Sign
*not necessary if this page is submitted as a complete packet

Company Name: ____

SERVICES PROTOCOL INFORMATION (INJURY)

Follow Written Authorization if different from Company Protocol? ☐ YES ☐ NO

Please note that **PROPERLY SIGNED AUTHORIZATION FORMS are required for treatment.

Allow verbal authorization? ☐ YES ☐ NO If YES, we need written authorization to follow as soon as possible.

Do you or your Insurance Carrier use a Durable Medical Equipment Program? ☐ YES ☐ NO

Do you or your Insurance Carrier use a Pharmacy Prescription Program? ☐ YES ☐ NO

Allow Transportation Authorization for Services other than First Injury? (Additional fees will apply) ☐YES ☐NO

Accommodations for Modified Work Available? ☐ YES ☐ NO

Need Online Access for Medical Reports, Physicals, Drug Results and Account Status Report? ☐ YES Email: ________________ ☐

Send Progress Note(s)/Follow Up Status through: Email: ____________________ Other: ________________________

INJURY to the employee protocol:

A. DRUG TESTING REQUIRED: ☐ Yes ☐ No ☐ Upon Request ONLY

☐ Instant Drug Test (*Quick Test*) ☐ 5 Panel ☐ 10 Panel With Confirmation on Non Negative ☐ YES ☐ NO

☐ Drug Screen (*DSS*) Send to COMP's Lab ☐ NIDA ☐ NON-NIDA

☐ Urine Collection (*Drug Test*) – Send to other Labs: Laboratory: ______________________________

☐ Hair Collection (*Drug Test*) – Send to other Labs: Laboratory: ______________________________

B. BREATH ALCOHOL TEST REQUIRED: ☐ Yes ☐ No ☐ Upon Request ONLY

Special Instructions/ REMARKS: ____

ACCIDENT OR COLLISION without injury to the employee:

A. DRUG TESTING REQUIRED: ☐ Yes ☐ No ☐ Upon Request ONLY

☐ Instant Drug Test (*Quick Test*) ☐ 5 Panel ☐ 10 Panel With Confirmation on Non Negative ☐ YES ☐ NO

☐ Drug Screen (*DSS*) Send to COMP's Lab ☐ NIDA ☐ NON-NIDA

☐ Urine Collection (*Drug Test*) – Send to other Labs: Laboratory: ______________________________

☐ Hair Collection (*Drug Test*) – Send to other Labs: Laboratory: ______________________________

B. BREATH ALCOHOL TEST REQUIRED: ☐ Yes ☐ No ☐ Upon Request ONLY

Special Instructions/ REMARKS: ____

____________________ **EMPLOYER'S AUTHORIZED SIGNATURE** ________________
*Print Name *Sign
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SERVICES PROTOCOL INFORMATION (PRE-EMPLOYMENT)

PRE-EMPLOYMENT SERVICES for the employee:

A. DRUG TESTING REQUIRED: ☐ Yes ☐ No ☐ Upon Request ONLY

☐ Instant Drug Test (*Quick Test*) ☐ 5 Panel ☐ 10 Panel With Confirmation on Non Negative ☐ YES ☐ NO

☐ Drug Screen (*DSS*) Send to COMP's Lab ☐ NIDA ☐ NON-NIDA

☐ Urine Collection (*Drug Test*) – Send to other Labs: Laboratory: ______________________________

☐ Hair Collection (*Drug Test*) – Send to other Labs: Laboratory: ______________________________

B. BREATH ALCOHOL TEST REQUIRED: ☐ Yes ☐ No ☐ Upon Request ONLY

Special Instructions/ REMARKS: ____

C. PHYSICAL EXAM REQUIRED: ☐ Yes ☐ No ☐ Upon Request ONLY

Physical Description **(Service Times 8:30am-4:45pm (Mon-Fri) except Holidays)**

☐ Basic Physical Exam (includes Medical History Review, Medical Examination, Blood Pressure, Vitals)

☐ Physical Exam (includes Medical History Reviewed, Medical Examination, Blood Pressure, Vitals, Vision (Neer, Far, Peripheral and Color), Urinalysis and Audiogram)

☐ DOT Physical

☐ Return to Work (fit for duty) Physical Exam

☐ EDEX (background check on permanent work restrictions {must be done in combination with a Physical})

☐ Audiogram/Hearing Test

Special Instructions/ REMARKS: ____

D. ADDITIONAL SERVICES REQUIRED: ☐ Yes ☐ No ☐ Upon Request ONLY

☐ Physical Agility Test with Lift Testing and Back Training _____ Lbs

☐ Lift and Carry Functional Testing with Back Training _____ LBS

☐ Back Training With Educational Materials and Demonstration (no patient lifting)

☐ EDEX (background check on permanent work restrictions {must be done in combination with a Physical})

☐ JAMAR (Grip Strength Measurement Using Special Equipment)

☐ Pulmonary Function Test w/ Respiratory OSHA Questionnaire

☐ Mask Fit

☐ Respiratory Question

☐ Chest X-Ray ☐ 1 View ☐ 2 Views

☐ Back X-Ray ☐ 2 Views ☐ 3 Views ☐ 5 Views

Special Instructions/ REMARKS: ____

E. INJECTIONS REQUIRED: ☐ Yes ☐ No ☐ Upon Request ONLY **(availability may be limited) **

☐ Tetanus

☐ T-dap

☐ Varicella Vaccine

☐ Hepatitis B 3 series

☐ Flu Vaccine

☐ PPD/ TB Test

☐ MMR Vaccine

_____________________ **EMPLOYER'S AUTHORIZED SIGNATURE** _____________________
*Print Name *Sign
*not necessary if this page is submitted as a complete packet

Company Name: ____

Workers Compensation Compliance Notices

CLAIM FORM, FIRST AID

5401. (a) Within one working day of receiving notice or knowledge of injury under Section 5400 or 5402, which injury results in lost time beyond the employee's work shift at the time of injury or which results in medical treatment beyond first aid, the employer shall provide, personally or by first-class mail, a claim form and a notice of potential eligibility for benefits under this division to the injured employee, or in the case of death, to his or her dependents.

As used in this subdivision, "first aid" means any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injury, which do not ordinarily require medical care. This one-time treatment, and follow-up visit for the purpose of observation, is considered first aid even though provided by a physician or registered professional personnel. "Minor industrial injury" shall not include serious exposure to a hazardous substance as defined in subdivision (i) of Section 6302. The claim form shall request the injured employee's name and address, social security number, the time and address where the injury occurred, and the nature of and part of the body affected by the injury. Claim forms shall be available at district offices of the Employment Development Department and the division. Claim forms may be made available to the employee from any other source.

PROVISION OF CARE and LIABILITY FOR CLAIM

5402. (a) Knowledge of an injury, obtained from any source, on the part of an employer, his or her managing agent, superintendent, foreman, or other person in authority, or knowledge of the assertion of a claim of injury sufficient to afford opportunity to the employer to make an investigation into the facts, is equivalent to service under Section 5400.

(b) If liability is not rejected within 90 days after the date the claim form is filed under Section 5401, the injury shall be presumed compensable under this division. The presumption of this subdivision is rebuttable only by evidence discovered subsequent to the 90-day period.

(c) Within one working day after an employee files a claim form under Section 5401, the employer shall authorize the provision of all treatment, consistent with Section 5307.27, for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($10,000).

(d) Treatment provided under subdivision (c) shall not give rise to a presumption of liability on the part of the employer.

Acknowlegement:

___________________________ _____________
Print Name Date

____
Signature

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If this page is submitted with page 1, not necessary to complete above

BILL TO INFORMATION

*Address information is not necessary if this page is submitted as a complete packet

Recordable Claim: ☐ Insurance Carrier ☐ TPA

Mailing Address: ____ City: __________________ State: _________ Zip: __________

Contact: _________________________ Email: ________________________ Phone #: _______________ Fax #: _________________

First-Aid: ☐ Company ☐ Corporate ☐ Insurance Carrier ☐ Bill Reviewer ☐ TPA ______________________________

Mailing Address: ____ City: __________________ State: _________ Zip: __________

Contact: _________________________ Email: ________________________ Phone #: _______________ Fax #: _________________

Non-Industrial: ☐ Company ☐ Corporate ☐ Insurance Carrier ☐ Bill Reviewer ☐ TPA ______________________________

Mailing Address: ____ City: __________________ State: _________ Zip: __________

Contact: _________________________ Email: ________________________ Phone #: _______________ Fax #: _________________

Post Injury Drug Test/BAT: ☐ Company ☐ Corporate ☐ Insurance Carrier ☐ Bill Reviewer ☐ TPA ______________________________

Mailing Address: ____ City: __________________ State: _________ Zip: __________

Contact: _________________________ Email: ________________________ Phone #: _______________ Fax #: _________________

Claim Number Contact Person: ____

Email: ______________________________________ Phone #: ________________________ Fax #: ________________________

Claim # for Injuries must be submitted to COMP with **5 days from DATE of SERVICE, Claim #s can be emailed directly to claimnos@cenocc.com

Pre-Employment bills to: ☐ Company ☐ Corporate ☐ Laboratory ☐ TPA ____

Mailing Address: ____ City: __________________ State: _________ Zip: __________

Contact: _________________________ Email: ________________________ Phone #: _______________ Fax #: _________________

All Invoices are due **45 days from postage date to be in compliance. **Finance charges of 15% and penalty charges of 10%** will be imposed for Late Payments after the Due Date indicated.

Employer's Name ____ Title____

Employer's Signature ____ Date Submitted _______________________________

SAMPLE SIGNATURES FOR AUTHORIZING SUPERVISORS

FOR INJURY:

Supervisor's Signature ____ Title ____
Print Name and Sign

FOR PRE-EMPLOYMENT:

Supervisor's Signature ____ Title ____
Print Name and Sign

↓↓↓ For COMP's Use Only ↓↓↓

Marketer's Name __William Martinez________________________ Date Submitted_______________________________
Print Name and Sign

Marketing Director's Signature ___________________________ Date Received by Billing Dept ___________________
Print Name and Sign

Billing Department______________________________________ Date Approved and Entered ______________________
Print Name and Sign