MultiCare Centers of Occupational Medicine
BetterConnected

multicareoccmed.org

Workers Compensation Protocol Enrollment Form

To set up protocols in our system to support your workers compensation program, please complete this form and return to Account Services email to occmed@multicare.org (preferred), or fax to 253-459-6708

Company/Employer

Company Name: ______ Dept / Division: ______

Primary Workers Comp Contact: ______ Contact Tel: ______

Contact Email: ______ Contact Fax: ______

Contact Address
Address
City, ST, Zip

Facility Address _____ Same as contact address. _____ See attached list.
Address
City ST Zip

Coverage

____ Washington L&I ____ Self-Insured (complete billing information below)

MultiCare OccMed Office Use	
Company ID: ______	Bill To Name
Plan ID: ______	Address
L&I Acct: ______	City, ST Zip
	Phone, Fax
	Claim Manager

Post-Injury Drug & Alcohol Testing

Post-injury drug & alcohol testing requires the Drug & Alcohol Testing Enrollment Form.

When to Test	*What Test*
____ Never perform drug or alcohol tests	____ Drug Test
____ Always perform test at initial visit	____ Breath Alcohol Test
____ Only test upon request by supervisor	

Visit Document Resulting

Complete this section to automatically receive a copy of the Activity Prescription Form (APF) or other employer documents following an injury care appointment.

____ Do not send an employer copy

____ Email

____ Secure fax number*: ______

**By indicating fax resulting, the employer confirms employee/ candidate private information will be protected when sent to the above number.*

____ US Mail to:

Address

City, State, Zip

Additional documents requested (describe, send blank copies) ______

Enrollment Form Completed by

Print Name ______ Print Title ______

Signature ______ Date ______

MultiCare Occupational Medicine-Account Services
p 253.459.6541 | e occmed@multicare.org