Dignity Health.
Pacific Central Coast Health Centers
Med Plus

Employer Enrollment Form

In order for our office to provide you and your employees with the best care possible our office asks that you answer the following questions and return this form to our office prior to sending any patients in for medical treatment.

Company Name_____ # of Employees _____

Physical Address_____

Mailing Address_____

Phone_____ Fax_____

Contacts: Name Position Email

1. _____
2. _____
3. _____
4. _____

Worker's Compensation Carrier _____

Claims Mailing Address _____

Phone_____ Fax_____

Policy Number_____ Exp. Date_____

What services is your company interested in? (Please check all that may apply)

Physicals	**Drug Testing**	**Ancillary Services**	**Work Related Injuries**
☐ Annual Physicals	☐ Pre-Employment	☐ TB Testing	☐ Worker's Comp Billing
☐ DMV Clearance	☐ Post-Accident	☐ Vision Screening	☐ First Aid Billing (*)
☐ Other _____	☐ Random/Cause	☐ Audio Screening	☐ (*) At Dr's Discretion

If you are interested in drug testing employees:

1. Do you require Non-DOT or DOT Drug Screening? _____
2. Do you require Breath Alcohol Screening?_____
3. Do you have your own lab or would you like us to use ours? _____

If you have your own lab/3rd party administrator please indicate) _____

Please list any additional testing requirements or specified requests_____

_____

Once you have completed this form please fax it to appropriate clinic (see fax numbers below).
If you have additional questions, please contact Manager of Business Integration,
Corinne Friedling, 805.835.5376, corinne.friedling@dignityhealth.org.
For any billing questions contact Renee, 805.928.1260 or email Renee.McQuirter@DignityHealth.org.

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