HealthCor
Corporate Medical Services

Joseph J. Ciuffo MD F.A.A.F.P.
Medical Director

AUTHORIZATION/REFERRAL FOR MEDICAL SERVICES

A.) AUTHORIZATION

Company Name: _____

Name of Applicant/Employee: _____

Date of Service: _____

Applicant's Social Security Number: _____

Authorized By: Signature:_____ Print:_____

B.) BILLING

_____EMPLOYEE/APPLICANT TO PAY _____BILL SERVICES TO COMPANY

C.) SERVICES TO BE PROVIDED

1) PLEASE CHECK CATEGORY OF TESTING REQUIRED:

Pre-Employment	Periodic Recertification	Random
Post-Accident	Reasonable Cause	Return to work

2) PLEASE CHECK SERVICE(S) REQUIRED:

Physical Examination (DOT) (NON-DOT)	Urine Collection (DOT) (NON-DOT)	Breath Alcohol Testing
Medical Evaluation	Work Related Injury	Respiratory Testing
Lead/ZPP Testing	Other: _____	

AFTER COMPLETING ABOVE RETURN BY:

Email to: support@healthcor.org or Fax to: 718-457-5931

73-01 Grand Avenue * Maspeth * New York 11378
718-457-5900 * Fax: 718-457-5931