AnMed

AFTER HOURS INJURY FORM

Occupational Medicine
2000 East Greenville Street, Suite 1300, Anderson, SC 29621
Phone 864.512.4813 Fax 864.512.4808

To be seen after hours each company must complete this form and present at check in to any of the locations listed below:

AnMed Emergency Department
800 N. Fant St. Anderson, SC
29621 After 8:00pm weekdays
and after 5:00pm on weekends

AnMed Urgent Care – 801 N. Fant Street, Anderson, SC 29621
Phone: 864.642.3777
Hours of Operation:
Monday-Friday 8:00am - 8:00pm
Saturday 8:00am - 8:00pm
Sunday 8:00am - 8:00pm

AnMed Occupational Medicine is open Monday through Thursday 7:30-4:00 Closed each day from 12:00-1:00 Friday hours are 7:30-12:00.

Photo ID is required

Company Name: _____ Date: _____

Company Address: _____ Company contact phone number: _____

Employee (Patient) Name: _____ Date of Birth: _____

Authorized Company Representative (print): _____

Workers Compensation Billing Information: Complete the information below to bill this visit to a workers' compensation group or carrier.

Carrier Name: SCMIT

Mailing Address: PO Box 11447

City, State, Zip: Columbia, SC 29211

Date of Original Accident / Illness: _____ Claim Number: _____

Phone with Area Code: 803-799-9574 Fax with Area Code: 803-933-1299

Authorized Company Representative (print): Patrice Mattison – City of Anderson Human Resources Manager 864-332-5715

Services requested (check all that apply):

Drug testing:
- □ 6 panel rapid
- □ 10 panel rapid
- □ Hair drug screen

Alcohol testing
- □ Blood
- □ Breath

If "reasonable suspicion" drug testing is needed, the employee would need to be registered in admitting with this completed form.

I verify the information provided on this form is correct to the best of my knowledge.

I, _____ have been injured in an accident at my place of employment. I accept responsibility for any portion of my bill that may be rejected by my employer for any reason. The information I have given concerning the name, address and telephone number of my employer is, to the best of my knowledge, true and correct.

I authorize AnMed to contact my employer to verify the status of my employment & the validity of this Worker's Compensation Claim.

Patient Signature: _____ Date: _____