

# COVID-19 RAPID TESTING ON-SITE CLINIC



Office: 1-800-764-0418

## Company Paid Program. KMM does not bill insurance.

- ⇒ KMM works with Companies on payroll deduction programs or Company paid programs.
- ⇒ Company is to pay for service after clinic is provided.
- ⇒ Covid Rapid Testing Clinics that meet **minimum requirement** are available throughout Texas
- ⇒ Minimum requirements are required for certain areas outside of San Antonio, Texas and surrounding towns. Contact KMM for details.

## Types of Covid-19 Rapid Testing Available / Rates & Discounts

(Please check off which service you are interested in to book)

- 15-Minute Covid-19 Antibody Test (Blood prick)
- 1-10 employees per clinic location—\$65 per test
- 11-60 employees per clinic location—\$55 per test
- 61—or more per clinic location—\$45 per test
  
- 10-Minute Covid-19 Antigen Test (Mouth swab)
- 1-10 employees—\$115 per test
- 11-60 employees—\$100 per test
- 61 and more employees or more per clinic location—\$90 per test

## Accepted Form Of Payment

- KMM accepts all credit cards and bank drafting via our on line secured system at [www.kaisermedicalmanagement.com](http://www.kaisermedicalmanagement.com)
- Correct Cash
- Check (If an employee’s check is returned, Company agrees to assist KMM in getting funds from employee plus the \$25 bank charge return fee)
- VENMO App—@KaiserMedicalManagement

Covid-19 Rapid Testing Clinic

45-Day Notice Required / 60-Day Notice Required September—November

FAX TO 1-888-688-4176

[www.kaisermedicalmanagement.com](http://www.kaisermedicalmanagement.com)

You will be notified by email that we received fax.

## COVID-19 TESTING CLINIC REQUEST

Company Name: \_\_\_\_\_

Address of Location Of Clinic: \_\_\_\_\_

Location Within Company Where Clinic Will Be Held: \_\_\_\_\_  
(Cafeteria, Conference Room, Breakroom, Specific Room Name)

Point of Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Requesting DATE/DAY/TIME: \_\_\_\_\_  
(KMM holds the right to adjust time)

**Company Paid Program**

**Payroll Deduction Program**

**Employee Paid Program**

Please circle which program for billing

Estimated Number of employees to be administered: \_\_\_\_\_

KMM does not provide clinics **outside of the San Antonio** area if less than 11.

I authorize Kaiser Medical Management to provide \_\_\_\_\_ company a COVID-19 Rapid Testing Clinic. If applicable and if in the event an employee’s check bounces/insufficient funds/closed account, Company will assist KMM with assuring employee takes care of their responsibility of payment and any bank fee’s.

Authorized Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_