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VERIFICATION OF WORK RELATED INJURY

(Updated 6-2015)

Patient Name: ____ DOB: __________________________

Address: ____ SSN: __________________________

Patient Phone: _____________________________ Patient Alt Phone: ____________________________

Date of Injury/Illness: ____ Time: ___________________ am/pm

Place Accident Occurred: ______________________________________ Parish: _________________________

Area of Body Injured: ____ Side: __________________________

Name of Employer: _____________________________________ Occupation: ___________________

Employer Address: ____

Employer Case Manager:__________________________ Phone:_________________ Fax: _______________

Company Physician: _____________________________ Phone:_________________ Fax:________________

Employer acknowledges that the patient listed above was involved in a work place injury while employed for the designated employer. As a work-related injury, the employee, employer and provider(s) maintain certain rights and responsibilities as governed by applicable law. As an ***authorized*** signature for the company, representative below confirms that this injury **is work-related** and that claims will be paid promptly, subject to applicable fee schedule and regulations. Payment for medical care rendered shall be assigned directly to the provider group. Employer is responsible for paying any and all collection costs associated with untimely or non-payment.

This injury/illness falls under the authority off:

______LA Workers' Compensation Law – subject to LA WC Fee Schedule (Title 40)
______Jones Act Law (46 U.S.C. 688 (1970.)
______Long Shore Harbor Workers' Compensation Law (33 USC § 90) *(Must Submit Copy of LS202)*
______Parish Sheriff's Deputy (Title 40 §1034, Sect. B)
______Federal Office of Workers' Compensation Plan (OWCP)
______Other State Workers Compensation. State of___________________ (Must coincide with place of injury)

Medical claims for services shall be sent to:

____
____
____
____

Fax Completed Form To: 985.625.2206

Work Related Claim #_______________________ Date Accident Reported _________________

Adjuster Name: ____________________________ Adj Phone: ____________________ Adj. Fax: ___________________

_____________________________ ___________________________________ __________________________

Authorized Signature of Employer Printed Employer Representative's Name Date