

Allen T. Borne, MD
David W. Elias, MD
Patrick R. Ellender, MD
Eric M. Greber, MD
Jason A. Higgins, MD
John C. Hildenbrand IV, MD
William S. Johnson III, MD
Richard A. Morvant, Jr., MD



726 N. Acadia Road – Suite 1000
Thibodaux, LA 70301
Phone (985) 625-2200
Fax (985) 625-2201
www.ortho-la.com

VERIFICATION OF WORK-RELATED INJURY

(Updated 10-2018)

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:
985.625.2201**

Work Related Claim # _____ Date Accident Reported _____
Adjuster Name: _____ Adj Phone: _____ Adj. Fax: _____

Authorized Signature of Employer Printed Employer Representative's Name Date