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

orthoLA
Orthopaedic Sports Medicine, Joint and Hand Specialists

Locations:
Thibodaux – 726 N. Acadia Rd. Ste 1000
Houma – 180 Corporate Dr.
Raceland – 141 Twin Oaks Dr.
Laplace – 502 Rue de Santé Ste 106
Phone: (985)625-2200 Fax: (985)625-2206
www.orthola.com

VERIFICATION OF WORK-RELATED INJURY

(Updated 02-2019)

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: _____

Case Manager Email: _____

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: _____

Adj Email: _____

_____ _____ _____

Authorized Signature of Employer | Printed Employer Representative's Name | Date