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
William S. Johnson III, MD
Lacey L. Giambelluca, MD
Russell D. Parks, MD

orthoLA
Orthopaedic Sports Medicine, Joint and Hand Specialists

Thibodaux – 726 North Acadia Road
Franklin – 1029 Northwest Boulevard
Lutcher – 1731 Lutcher Avenue
Raceland – 4560 Highway One
Houma – 180 Corporate Drive
Laplace – 465 Belle Terre Boulevard

VERIFICATION OF WORK-RELATED INJURY

REQUESTED PHYSICIAN

PATIENT NAME: _____ **DATE OF BIRTH:** _____
ADDRESS: _____ **SOCIAL SECURITY #:** _____
PATIENT PHONE #: _____ **ALTERNATE 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 #:** _____
CASE MANAGER EMAIL ADDRESS: _____ **FAX #:** _____
COMPANY PHYSICIAN: _____ **PHONE #:** _____
FAX #: _____

Employer acknowledges that the patient listed above was involved in a work place injury while employed for the employer listed above. When a work-related injury occurs, 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 will be assigned directly to the provider group. Employer is responsible for paying any costs associated with collection of these fees.

THIS INJURY/ILLNESS FALLS UNDER THE AUTHORITY OF:

◯ **LOUISIANA 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 U.S.C. § 90)**
◯ **PARISH SHERIFF'S DEPUTY (Title 40 § 1034, Section B)**
◯ **FEDERAL OFFICE OF WORKERS' COMPENSATION PLAN (OWCP)**
◯ **OTHER STATE WORKERS' COMPENSATION—STATE OF _____ (Must coincide with place of injury)**
◯ **DIRECT PAY BY EMPLOYER**

ADDRESS FOR MEDICAL CLAIMS FOR SERVICES:

_____
_____
_____
_____

COMPLETED FORM SHOULD BE FAXED TO:
985-625-2206

WORK RELATED CLAIM #_____ **DATE ACCIDENT REPORTED:** _____
ADJUSTER NAME: _____ **PHONE:** _____ **FAX:** _____
ADJUSTER EMAIL: _____

NAME OF AUTHORIZED EMPLOYER REPRESENTATIVE: _____
SIGNATURE OF EMPLOYER REPRESENTATIVE: _____ **DATE:** _____

*****If the employer is the responsible party for the patient's care, orthoLA requires a $300.00 non-refundable deposit for the initial visit and xrays.*****