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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) (Must submit copy of LS202)
- 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:

**RETURN COMPLETED FORM VIA EMAIL TO
 WC@ORTHO-LA.COM OR FAX 985-492-1212**

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.*****