pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

WORKERS' COMPENSATION MEDICAL REPORT FORM

THIS FORM IS TO BE FILED WITH THE EMPLOYER OR INSURER ACCORDING TO INSTRUCTIONS PROVIDED ON THIS FORM.

Name of employee _____

Name of employer _____

Name of insurer _____

WCAIS claim number _____ Date of birth _____

Employee SS# XXX-XX-____ ____ ____ ____ Date of injury _____
Or
WC ID number _____

Date of report _____

Provider name _____

Provider address _____

Contact person _____ Telephone _____

Health care providers shall complete and submit the appropriate HCFA billing form and needed documentation to the employer. If the employer is covered by an insurer, the appropriate billing form and documentation is to be sent to the insurer. The LIBC-9 form and required accompanying documentation shall be submitted within 10 days of commencing treatment and at least once a month thereafter, as long as treatment continues. If a provider does not submit the required medical reports in the prescribed format, the employer/ insurer is not obligated to pay for such treatment until the required report is received by the employer/ insurer.

Documentation shall include (where pertinent) claimant's history, diagnosis, description of treatment and services rendered, physical ¿ndings and prognosis including whether or not there has been recovery enabling the claimant to return to work with or without limitations, and speci¿c restrictions, if any, regarding return to work. Bills for follow-up visits should include progress/of¿ce notes to support the diagnosis and codes billed.

Providers may not charge for documentation supporting a claim for payment. Providers may charge their usual fee for special reports speci¿cally requested by the employer/insurer. All patient information shall be submitted with the knowledge of the patient and must be maintained as con¿dential by the employer/insurer. The employer/insurer shall not be liable to pay for treatment until the required documents have been provided.

Listed on the reverse are guidelines for the completion of billing forms and submission of records.

BILLING FORM GUIDELINES:

Requests for payment of medical bills shall be made either on the HCFA Form 1500 or the UB92 Form, or any successor forms required by HCFA/CMS. Forms must be signed or typed with the name of the provider. Name and signature (if signature is used) must match.

Cost-based providers shall submit a detailed bill including service codes and rev codes consistent with the service codes and rev codes submitted to the Bureau of Workers' Compensation on the detailed charge master.

Until a health care provider submits bills on one of the forms speci¿ed above, employers/insurers are not required to pay for the treatment billed.

MEDICAL REPORT FORM GUIDELINES:

This form must be submitted within 10 days of initial treatment and monthly thereafter, and must be accompanied by documentation to support the billing.

Suggested supporting documentation:

Physicians — Of¿ce notes
Physical/Occupational therapists — Daily treatment records/notes with physician referral
Pharmacies — NCD#, amount dispensed, RX#
DME vendor — Medicare/HCPC code, certi¿cate of medical necessity
Chiropractors — Treatment notes
Ambulance providers — Medicare codes, notes/reports
X-ray/MRI facilities — Reports
Lab Facilities — Test results
Anesthesia services — ASA code, base/time units, anesthesia record
Hospitals — Records from area providing the service (e.g. emergency, outpatient surgery...)
Inpatient hospital admissions — H&P, discharge summary, operative report (if applicable)
CORFs & Rehabilitation Centers — Daily treatment notes, including physician orders
Ambulatory surgery centers — Notes and reports

General for all providers: Use the most appropriate and speci¿c HCFA/CMS coding on billing. When using miscellaneous codes, include detailed description of services.

Any individual ¿ling misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

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Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

WORKERS' COMPENSATION INJURY QUESTIONNAIRE

Please Print:

Name_____ Today's Date_____

Employer's Business Name at time of Accident:

_____

Employer's Phone:_____

Employer's Address:_____

City_____State_____Zip_____

Occupation:_____

Previous Workers' Compensation Injury? ❑ YES ❑ NO

Length of time at this job prior to injury:_____

Date of injury:_____ Time of injury:_____ Last Date Worked:_____

Please explain what you were doing at the time you were injured and how the accident happened (lifting, bending, walking, carrying, standing, etc.) _____

_____

_____

When did the pain begin? (be specific)_____

Where did you first feel the pain? (be specific)_____

Was the pain intense at first, or did it gradually worsen? _____

REPORT ACCIDENT/ACCIDENT OBSERVER

What date did you report this injury on? _____

Who did you report this injury to? _____ Position_____

Did anyone else observe accident/injury? ❑ YES ❑ NO

If YES, Name:_____ Position_____

SYMPTOMS FROM ACCIDENT

Did you experience bleeding cuts or bruises? ❑ NO ❑ YES

If bleeding, where:_____

If bruises, where:_____

Please describe how you felt. BE SPECIFIC

Immediately after the accident:_____

Later that day:_____

The next day(s):_____

Check the symptoms that have become apparent since the accident/injury:

- ❑ Neck Pain/Stiffness
- ❑ Headache
- ❑ Nervousness
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Loss of Memory
- ❑ Fainting
- ❑ Pain behind Eye(s)
- ❑ Ringing/Buzzing in Ears
- ❑ Heavy Head
- ❑ Constipation
- ❑ Tension
- ❑ Confusion
- ❑ Mid-Back Pain/Stiffness
- ❑ Chest Pain
- ❑ Loss of Balance
- ❑ Dizziness
- ❑ Cold Hands
- ❑ Cold Feet
- ❑ Anxiety
- ❑ Cold Sweats
- ❑ Fever
- ❑ Irritability
- ❑ Diarrhea
- ❑ Blurred Vision
- ❑ Disorientation
- ❑ Low Back Pain/Stiffness
- ❑ Sciatic Pain/Pain down legs
- ❑ Sleeping Trouble
- ❑ Toe numbness
- ❑ Pins and Needles - Hands
- ❑ Pins and Needles - Legs
- ❑ Seizures
- ❑ Face Flushed
- ❑ Shortness of Breath
- ❑ Depression
- ❑ Fatigue
- ❑ Double Vision
- ❑ Other_____

MECHANISM OF INJURY:

Please explain the mechanism of the injury (only fill in those sections that apply to you):

FALL:

Did you hit anything when you fell? ❑ YES ❑ NO

If yes, what?_____

Were you carrying anything when you fell? ❑ YES ❑ NO

If yes, what?_____

How much did it weigh? _____lbs.

Did you twist when you fell? ❑ YES ❑ NO

If so, which side? ❑ LEFT ❑ RIGHT

Was the area lighted? ❑ YES ❑ NO

Describe the condition of the area (slippery, graveled, etc.)_____

_____

What part of the body did you fall on?_____

LIFT/PULL:

How much did the object weigh? _____lbs.

Did you fall after the injury? ❑ YES ❑ NO

If yes, how?_____

Did you hit anything when you fell? ❑ YES ❑ No

If yes, what?_____

Were you twisting what you were lifting/pulling? ❑ YES ❑ NO

If so, to which side? ❑ LEFT ❑ RIGHT

How far off the ground did you have the object before the pain started?_____ft._____in.

Did you drop the object when the pain started? ❑ YES ❑ NO

If so, did it land on you? ❑ YES ❑ NO

If it landed on you, where?_____

Did you lift with your: ❑ LEGS ❑ BACK ❑ OTHER_____

BEND:

Were you lifting when you were bent over? ❑ YES ❑ NO

If yes, how much did the object weigh?_____lbs.

How far were you bent over?_____degree angle.

Did you fall when the pain started? ❑ YES ❑ NO

If yes, how far?_____

Were you twisting when you bent forward? ❑ YES ❑ NO

If so, to which side? ❑ LEFT ❑ RIGHT

Did you land on anything? ❑ YES ❑ NO

If so, what?_____

WORK STATUS HISTORY:

Have you lost time from work as a result of this new injury? ❑ YES ❑ NO

If yes, please give dates:_____

Have you gone back to work? ❑ YES ❑ NO

If yes, status of work: ❑ Modified ❑ Regular

If modified, list restrictions you have been placed on:_____

_____

If you've gone back to work, list activities that are painful or difficult:_____

_____

If you are currently on disability, (time loss) do you want to go back to work doing your regular job?

❑ YES ❑ NO

If no, why?_____

Are there any problems you have with a fellow employee, supervisor, or manager that needs to be discussed? ❑ YES ❑ NO

If yes, please explain:_____

_____

_____

FIRST DOCTOR/HOSPITAL/CLINIC:

Were you hospitalized as a result of this accident? ❑ YES ❑ NO

If yes, where?_____

Doctor #1 Name_____ Date_____

Were you examined? ❑ YES ❑ NO

Were X-Rays taken? ❑ YES ❑ NO

What diagnosis did the Doctor give you?_____

_____

Were you given any treatment? ❑ YES ❑ NO

If yes, what type?_____

What benefits did you receive from this treatment?_____

_____

Date of last treatment:_____

Did the Doctor refer you to another health professional? ❑ YES ❑ NO

If yes, to whom?_____

For what reasons?_____

Did you follow the Doctor's recommendation? ❑ YES ❑ NO

If no, why not?_____

_____

SECOND DOCTOR/CLINIC:

Doctor #2 Name_____ Date_____

Were you examined? ❑ YES ❑ NO

Were X-Rays taken? ❑ YES ❑ NO

What diagnosis did the Doctor give you?_____

_____

Were you given any treatment? ❑ YES ❑ NO

If yes, what type?_____

What benefits did you receive from this treatment?_____

_____

Date of last treatment:_____

PRIOR SIMILAR SYMPTOMS:

Did you have any physical complaints just before the accident? ❑ YES ❑ NO

If yes, please describe in detail:_____

_____

_____

Have you ever had any prior injuries, accidents, diseases or treatment to the area of your body now affected? ❑ YES ❑ NO

If yes, what part(s)?_____

Date previously injured?_____

Were you treated? ❑ YES ❑ NO

If yes, by whom?_____

Date treatment began:_____ Date treatment ended:_____

The last date you felt pain or problems from that previous injury?_____

JOB DESCRIPTION

In terms of an 8 – hour workday:

Occasionally = 33% ***Frequently*** = 34& to 66% ***Continuously*** = 67% to 100%

In a typical 8 – hour workday, I (circle the number of hours of activity)

Sit	1	2	3	4	5	6	7	8	Hours
Stand	1	2	3	4	5	6	7	8	Hours
Walk	1	2	3	4	5	6	7	8	Hours

On the job, I perform the following activities:

	Not at all	Occasionally	Frequently	Constantly
Bend/Stoop	❑	❑	❑	❑
Squat	❑	❑	❑	❑
Crawl	❑	❑	❑	❑
Climb	❑	❑	❑	❑
Reach Above Head	❑	❑	❑	❑
Crouch	❑	❑	❑	❑
Kneel	❑	❑	❑	❑
Balancing	❑	❑	❑	❑
Pulling/Pushing	❑	❑	❑	❑

On the job, I lift:

Up to 10 pounds	❑	❑	❑	❑
11 to 24 pounds	❑	❑	❑	❑
25 to 34 pounds	❑	❑	❑	❑
35 to 50 pounds	❑	❑	❑	❑
51 to 74 pounds	❑	❑	❑	❑
75 to 100 pounds	❑	❑	❑	❑
Over 100 pounds	❑	❑	❑	❑

Are you required to bend over while doing any lifting? ❑ YES ❑ NO

Are your feet used in repetitive movements, such as operating foot controls? ❑ YES ❑ NO

Do you use your hands for repetitive actions such as:

	Simple Grasping	Firm Grasping	Fine Manipulating
Right Hand	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
Left Hand	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO

Are you required to work at unprotected heights? ❑ YES ❑ NO

If yes, please describe:_____

Are you required to be around moving machinery? ❑ YES ❑ NO

If yes, please describe:_____

Are you exposed to marked changes in temperature and humidity? ❑ YES ❑ NO

If yes, please describe:_____

Are you required to drive automotive equipment? ❑ YES ❑ NO

If yes, please describe:_____

Are you exposed to dust, flames, and/or gases? ❑ YES ❑ NO

If yes, please describe:_____

Please list any additional comments:_____

Signature_____ **Date**_____