

Dear Medical Provider:

The Illinois Worker's Compensation and Occupational Diseases Act provides that the employer is obligated to pay all medical, hospital and surgical charges incurred in connection with an accidental injury and/or disease which arises out of and in the course of employment. This obligation is "limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury or disease."

The Act further provides that "Every hospital, physician, surgeon or other person rendering treatment or services in accordance with the provisions of this Section shall upon written request furnish full and complete reports thereof to, and permit their records to be copied by, the employer\*\*\*."

The Act also provides that "in the event the (Illinois Workers' Compensation) Commission shall find that a doctor selected by the employee is rendering improper or inadequate care, the Commission may order the employee to select another doctor certified or qualified in the medical field for which treatment is required. If the employee refuses to make such change the Commission may relieve the employer of his obligation to pay the doctor's charges from the date of refusal to the date of compliance."

In accordance with the above provisions, you are requested to complete the attached medical report. Your timely furnishing of this report will work to the benefit of the injured employee in that it will enable Gallagher Bassett to make prompt decisions regarding the compensability of the injury and issuance of appropriate disability payments to the employee. Your detailed completion of this report is also necessary for us to process your itemized bill for payment.

Should any clarification of this report or copies of other medical records be required, we will specifically request same. Thank you in advance for your cooperation.

**INITIAL WORKERS' COMPENSATION MEDICAL REPORT**

Claim No. \_\_\_\_\_

The Illinois Workers' Compensation and Occupational Diseases Act provides that the employer is obligated to pay all first aid, medical and surgical services reasonably necessary to cure or relieve from the effects of occupationally-related injury or disease. Every hospital and doctor shall, upon written request, furnish complete records and permit their records to be copied by the employer and/or the employee.

Your detailed completion of this report is also necessary to enable our office to process your itemized bill for payment.

A. Employee's Name \_\_\_\_\_ Date of Report \_\_\_\_\_

Agency/Facility \_\_\_\_\_

Date of Accident \_\_\_\_\_ Date Examined \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Family Doctor  Specialist  Chiropractor  Other Number of years of Relationship \_\_\_\_\_

B. History (Description of Accident) \_\_\_\_\_

History of previous injuries and illnesses \_\_\_\_\_

Name(s) of other physician(s) who served on case \_\_\_\_\_

C. Diagnosis (ICD-9-CM Code(s)) \_\_\_\_\_

Describe nature and extent of injuries \_\_\_\_\_

D. Treatment (Proposed or completed, surgical, dressing(s), etc.) \_\_\_\_\_

Medications \_\_\_\_\_ (Given/Prescribed) \_\_\_\_\_

X-Ray Results (Attach copy of report) \_\_\_\_\_

E. Prognosis \_\_\_\_\_

Estimated date or return to work with restrictions \_\_\_\_\_ Identify Restrictions \_\_\_\_\_

Estimated date of return to work without restrictions \_\_\_\_\_

F. Final Report (Complete the following if treatment is no longer being rendered to this employee by the undersigned physician)

Date patient discharged from treatment \_\_\_\_\_ Case transferred to \_\_\_\_\_

Name of Doctor \_\_\_\_\_

(please print or type)

Address \_\_\_\_\_

Phone \_\_\_\_\_

DOCTOR'S SIGNATURE \_\_\_\_\_

Date \_\_\_\_\_