pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

IMPAIRMENT RATING DETERMINATION FACE SHEET

Bureau notification is performed by the examining physician's completion of the electronic version of this form in WCAIS.

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

___ - ___ - ____ ____

DATE OF INJURY

__ - __ - ____
MM DD YYYY

WCAIS CLAIM NUMBER

EMPLOYEE

First name _____

Last name _____

Date of birth _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____

ATTORNEY FOR EMPLOYEE (if known)

Name _____

Firm name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

Telephone _____ PA Attorney ID number _____

ATTORNEY FOR INSURER/EMPLOYER (if known)

Name _____

Firm name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

Telephone _____ PA Attorney ID number _____

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

NAIC code _____ or Insurer code _____

Insurer/TPA claim # _____

CLAIM REPRESENTATIVE

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

Telephone _____ FEIN _____

SEE IMPORTANT INFORMATION ON THE REVERSE

I examined the referenced employee, _____ , with regard to establishing an impairment rating determination to define the degree of impairment due to the compensable injury, if any, in accordance with the provision of Section 306(a.3) of the Pennsylvania Workers' Compensation Act.

Attached is the Report of Medical Evaluation prepared as utilized by the American Medical Association Guides to the Evaluation of Permanent Impairment 6th edition (second printing April 2009).

The original of this face sheet and report is being provided to the Bureau of Workers' Compensation, Healthcare Services Review Division, 1171 S. Cameron Street, Harrisburg, PA 17104-2501, with copies to the employee, the employee's attorney (if known) and the insurer within 30 days of the date of the impairment evaluation.

Name of patient: _____

Social Security number: **XXX-XX-** _____

Date of birth: _____

Date of this examination: _____

Percentage of impairment rating: _____ %

My charge of $ _____ will be billed to the Insurer or Third Party Administrator (if self-insured) for conducting this examination.

I attest that I am a physician in the Commonwealth of Pennsylvania and certified by an American Board of Medical Specialties approved board or its osteopathic equivalent, and that I have an active clinical practice of at least twenty (20) hours per week.

Physician

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

Telephone _____

Federal Tax ID number _____

NPI# _____

Specialty _____

Contact _____

_____
Provider or Representative's signature

Date of this notice

		-			-				
MM			DD			YYYY		

_____
Provider or Representative's name (typed/printed)

_____ _____
Telephone Email

Any individual filing 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
PA Relay 7-1-1

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

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