

NEW HAMPSHIRE WORKERS' COMPENSATION MEDICAL FORM

This form must be completed at each health professional visit (MD, DO, DC or DDS) and must be filed with the workers' compensation insurance carrier within 10 days of the treatment (first aid excluded). Failure to comply and complete this form shall result in the provider not being reimbursed for services rendered and may result in a civil penalty of up to \$2,500.

In compliance with RSA 281-A:23-b, the employer with 5 or more employees must provide temporary alternative/transitional work opportunities to all employees temporarily disabled by a work related injury or illness.

Employee _____ Employer _____
 SS# _____ Work telephone # _____
 Occupation _____ Employer contact _____
 Date last worked _____ Employer address _____
 W.C. insurer _____

HEALTH PROFESSIONAL TO COMPLETE

Initial visit Follow-up visit Date of Injury _____ Time _____

Worker's statement of the incident _____

Worker's complaints _____

Diagnosis/Prognosis _____

Treatment plan _____

In your opinion is this injury and disability as a result of injury described above? Yes No Unclear

EMPLOYEE WORK CAPABILITY

Continue Working Can return to work: Yes Date _____ No
 Full Duty With Modification. If so, for what duration? _____

Employee Can	No Restrictions	Frequently	Occasionally	Unable to	
bend					
kneel					
squat					
climb					
stand					
walk					
sit					
reach					
drive					
do fine motor					
No repetitive motions	Right	Wrist	Elbow	Shoulder	Ankle
	Left				

Employee can lift/carry maximally _____ lbs.
 Employee can lift/carry frequently _____ lbs.
 Employee can work a maximum of # _____ hours/day,
 # _____ days/wk.
 What special accommodations are required?

 Other _____
 Has employee reached maximum medical improvement?
 Yes No
 Has injury caused permanent impairment?
 Yes No Undetermined

ALL MEDICAL NOTES MUST BE ATTACHED TO BILL

I certify that the narrative descriptions of the principal and secondary diagnosis and the major procedures performed are accurate and complete to the best of my knowledge.

Provider's signature _____

Provider's Printed name _____

Provider's telephone # _____

Federal ID# _____

Date of Visit _____

MEDICAL AUTHORIZATION: The act of the worker in applying for workers' compensation benefits constitutes authorization to any physician, hospital, chiropractor, or other medical vendor to supply all relevant medical information regarding the worker's occupational injury or illness to the insurer, the worker's employer, the worker's representative, and the department. Medical information relevant to a claim includes a past history of complaints of, or treatment of, a condition similar to that presented in the claim. [281-A:23 V(a)]