WC-20a MEDICAL REPORT

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

MEDICAL REPORT

❑ Initial ❑ Interim ❑ Final

FAILURE TO SUBMIT THIS REPORT TO THE INSURER WILL JEOPARDIZE PAYMENT OF FEES

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

EMPLOYEE	Address	City	State	Zip Code	Phone Number	
EMPLOYER	Name		Mailing Address			
Phone Number		City		State	Zip Code	
INSURER / SELF-INSURER	Name		Mailing Address			
CLAIMS OFFICE	Name	Phone Number	City		State	Zip Code

1. Date disability began	2. Date of first treatment	3. Services authorized by ❑ Employer ❑ Dr. (name): _____ ❑ Other (specify): _____
4. Patient History		
5. Findings from Examination		6. Describe Diagnosis ICD-10 code
7. Describe Treatment		8. Prognosis

9. Date of maximum recovery	10. Doctors estimate of length of disability	11. Catastrophic Case Management Recommended
12. Date discharged as cured	13. Date patient stopped treatment without an order	14. Date patient refused treatment
15. a. Date patient able to return to work without restrictions b. Date patient able to return to work with restrictions c. List any restrictions	16. Hospital name and address if hospitalized	17. Does employee have any permanent disability? ❑ Yes ❑ No If yes, specify part of body Percentage based upon AMA guides _____ %

Date of Service	CPT/CDT Code	Medical, Surgical, and Dental Services / Drugs (itemize)	Units	Amount

Doctor's Name	FEIN / SSN	Address		
Doctor's Signature	Date	City	State	Zip Code
FILE THREE (3) COPIES WITH INSURER OR SELF-INSURER (PLEASE TYPE)				

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).