NEW HAMPSHIRE WORKERS' COMPENSATION MEDICAL FORM

New Hampshire ORTHOPAEDIC CENTER

This form must be completed at each professional visit (MD, DO, DC or DDS) and must be filed with the worker's compensation insurance carrier within 10 days or 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: _____
Employee Phone: _____
Occupation: _____ **DOB:** _____
SS # : _____**Claim:**_____
Date Last Worked: _____
W.C Insurer: _____
Phone # :_____ **Fax:** _____
Case Mgr: _____ **Fax:** _____

Employer: _____
Work Telephone: _____
Employer Address: _____
_____
Employer Contact: _____
Employer Fax #: _____

Referral Contact: _____

HEALTH PROFESSIONAL TO COMPLETE

☐ Initial Visit ☐ Follow-up Visit ☐ Phone Call Date of Injury: _____ Next Appt: _____
Worker's statement of the incident: _____
Worker's Complaints: _____
Diagnosis/Prognosis: _____
Treatment Plan: Treatment Plan Options (select one) _____
_____
In your opinion is this injury and disability as a result of the 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? __ please choose _____

Employee can	No Restrictions	Frequently	Occasionally	Unable to
bend	☐	☐	☐	☐
kneel	☐	☐	☐	☐
squat	☐	☐	☐	☐
climb	☐	☐	☐	☐
stand	☐	☐	☐	☐
walk	☐	☐	☐	☐
sit	☐	☐	☐	☐
reach	☐	☐	☐	☐
drive	☐	☐	☐	☐
do fine motor	☐	☐	☐	☐

No Repetitive Motions		Wrist	Elbow	Shoulder	Ankle
	Right	☐	☐	☐	☐
	Left	☐	☐	☐	☐

Employee can lift/carry maximally select _lbs.
Employee can lift/carry frequently select _lbs.
Employee can work a max. FT Hrs/Days FT Days/Wk.
What special accommodations are required? _____
please choose
_____
Other: _____
Has employee reached maximum medical improvement?
☐ Yes ☐ No Date MMI: TBD _____

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
		603-883-0091

Federal ID#	Date of Visit
02-0478308	

MEDICAL AUTHORIZATION: The act of the worker in applying for worker's 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)]

White: Org Chart **Yellow: Insurer** **Pink: Employee/Employer**