LAB 500

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 _____

Treatmentplan_

_____

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		Wrist	Elbow	Shoulder	Ankle
	Right				
	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)]