

## Workers' Compensation Services Information

The following is designed to help us understand and correctly represent your practice as it pertains to the treatment of injured workers.

- 1 Please check this box if you do not currently accept workers' compensation patients, or if you plan to discontinue your workers' compensation practice, or you are not certified/approved (if required by your state) to provide workers' compensation services.

Please complete and sign this information form if you currently accept workers' compensation patients, plan to continue your workers' compensation practice and are certified/approved (if required by your state) to provide workers' compensation services.

Please enclose a copy of your certification. Participation in the WC network may also include participation in a State Certified Managed Care Program (HCO,MCO,MCA)

1. My practice, for workers' compensation patients:

a. Can best be described as (check one box that best applies):

- Initial injury care for workers
- Initial visit for area of specialty care only Specialty: \_\_\_\_\_
- Specialty and/or referral care only Specialty: \_\_\_\_\_

b. Is limited in diagnosis and/or treatment as follows: \_\_\_\_\_

c. Is currently open: 1 Yes    1 No

d. Accommodates urgent walk-ins: 1 Yes    1 No

e. Accommodates appointments within 48 hours: 1 Yes    1 No

f. Has a physician on duty during all normal business hours: 1 Yes    1 No

g. Has the following services directly available in my office or immediately available on site (check all that apply):

- Laboratory Tests
- Lab Drawing Services only
- Routine Radiology
- Minor Surgery

2. My office staff is trained in the identification and care of occupational illness and injury: 1 Yes    1 No

3. My office staff will promptly provide information, consistent with state requirements, to workers' compensation representatives regarding a claimant's condition and care: 1 Yes    1 No

4. My office staff maintains an active return to work philosophy including cooperation on light or modified duty assessment: 1 Yes    1 No

### Provider Certification

I certify that the information in this application and attachments is true and correct. I understand that misrepresentation may result in my non-selection, or, if discovered after selection, in my termination as a network provider. I understand that this application does not entitle me to participation in The First Health® Network or the CCN® Network, both owned and operated by First Health and/or its subsidiaries (collectively "First Health"). I authorize First Health to consult with and inspect all documents from individuals and organizations having information bearing on my qualifications as a health care provider, and authorize the copy of my signature on this application to be as binding as the original. I agree that First Health, its representatives, and any individuals or entities providing information to First Health in good faith shall not be liable for any act or omission related to the evaluation or verification contained in this application. I further agree to notify First Health in a timely manner of any change to the information requested in this application. First Health will treat information requested in this application that is not publicly available as confidential. This authorization will remain valid until either, the date of my non-selection or my termination as a network provider. I acknowledge that I have the right to terminate this authorization at any time by providing written notice of my intent to terminate such authorization. However, I acknowledge that this may result in my termination as a network provider. I acknowledge that First Health or its representatives will only use this authorization for evaluation of my qualifications. Failure to update my information may result in termination as a network provider. I will retain a copy of this authorization for my own purposes.

A properly executed version of this document containing your actual signature, delivered by facsimile, is as valid as an original.

Physician/Health Care Professional Name (please print or type)

Physician/Health Care Professional Signature \_\_\_\_\_ Date \_\_\_\_\_  
(original signature required)