

WORKERS' COMPENSATION TREATMENT PLAN

THIS SECTION TO BE COMPLETED BY THE EMPLOYER

Patient Information	Employer Information	Medical Provider Information
Name	Name	Name
Address	Address	Address
Phone	Phone	Phone
Claim Number		Visit Date
Date of birth		
Date of injury		
Job title		

THIS SECTION TO BE COMPLETED BY THE TREATING PHYSICIAN

Assessment		
Diagnosis/ICS9 code		
Treatment rendered	X-rays of	
	Meds (prescription)	
	Meds (nonprescription)	
Treatment plan	Scheduled appointment/referrals	
	To specialist	
	Date	Time
	Return appointment scheduled	
	Date	Time
Return-to-work disposition		
<input type="checkbox"/> Restricted duty	From date	To date
List restrictions		
<input type="checkbox"/> Full duty, WITHOUT restrictions	Beginning date	<input type="checkbox"/> Pending reevaluation
I understand that it is my responsibility to supply a copy of this form to Summit via fax within 24 hours of this patient's visit.		
Physician's signature		Date

THIS SECTION TO BE COMPLETED BY THE PATIENT

I hereby authorize the treating physician to disclose any information regarding this incident to Summit. By signing below, I also release the physician from any liability arising from such disclosure.	
Patient's signature	Date

This form should be faxed to 770-718-9490 by the physician's office within 24 hours of the patient's visit.



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The following workers' compensation payors lease and have access to the Heritage Summit HealthCare LLC preferred provider network: Bridgefield Casualty Insurance Company, Bridgefield Employers Insurance Company, BusinessFirst Insurance Company, Retailers Casualty Insurance Company and RetailFirst Insurance Company.