|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| (Select one)  Language  Preference | English  Spanish  Russian  Korean  Chinese  Vietnamese  Laotian  Cambodian  Other       **MAIL TO SELF-INSURED COMPANY** | | | | | |  | | | | | | | **PROVIDER’S INITIAL REPORT** | | | | | | | | | | | | | | | |
| **A Provider’s Initial Report (PIR) completed by the provider and the worker, establishes a claim. When the completed PIR is received by the employer, they must assign a claim number and adjudicate the claim.** | | | | | | | | | | | | | | | | | | | | | | | | | | | 1.CLAIM NUMBER | | |
| 1. NAME OF SELF-INSURED EMPLOYER | | | | | | | **PATIENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | |
| ADDRESS | | | | | | | 2. NAME OF INJURED WORKER: FIRST MIDDLE LAST | | | | | | | | | | | | | | | | | | | 3. WORKER’S TELEPHONE NO. | | | | |
| CITY | | | | | STATE | ZIP | 4. MAILING ADDRESS | | | | | | | | | | | | | | | | | | | 5. SOCIAL SECURITY NUMBER | | | | |
| 2. NAME OF SELF-INSURED EMPLOYER’S SERVICE REPRESENTATIVE  PSWCT | | | | | | | 6. CITY | | | | | STATE | | | | | ZIP | | | | | | | | | 7. DATE OF BIRTH | | | | |
| ADDRESS  800 Oakesdale Ave SW | | | | | | | 8. INJURY DATE | | | | 9. TIME | | | | | AM  PM | | | | 10. Have you missed work due to your injury?  If so, what dates were you off? | | | | | | | | | | |
| From: | | | | | | | | | To: | |
| CITY  Renton | | | | | STATE  WA | ZIP  98057 | 11. SEX | | 12A. MARITAL/REGISTERED DOMESTIC  PARTNERSHIP STATUS | | | | | | | | | | | | | | | | | | 12B. NUMBER OF DEPENDENTS | | | |
| EMPLOYER’S TELEPHONE NUMBER | | | | EMPLOYER’S SERVICE REP PHONE  425-917-7667 | | | 13. Describe in detail how your injury or exposure occurred: | | | | | | | | | | | | | | | | | | | | | | | |
| Attending Health Care Provider – **START HERE** | | | | | | |
| 3. This exam date | | | | | | |
| 4. Date patient first seen by you for this injury/condition | | | | | | | **14. MEDICAL RELEASE AUTHORIZATION: PURSUANT TO RCW 51.36.060, I HEREBY AUTHORIZE MY HEALTH CARE PROVIDER, HOSPITAL, AGENCY OR ORGANIZATION TO DISCLOSE TO MY EMPLOYER OR MY EMPLOYER’S REPRESENTATIVE OR THE DEPARTMENT OF LABOR & INDUSTRIES ANY RELEVANT MEDICAL RECORDS OR OTHER INFORMATION REGARDING TREATMENT WHICH HAS PREVIOUSLY BEEN FURNISHED TO ME.** | | | | | | | | | | | | | | | | | | | | | | | |
| a. ICD Dx CODES | | | b. Diagnosis – specify Right/Left | | | |
|  | | |  | | | |
|  | | |  | | | | Worker’s Signature | | | | | | | | | | | | | | | | | | Date | | | | | |
| 5. Are there objective findings to support this diagnosis  No  Yes, Specify | | | | | | | 15. I have read the statement of Responsibility and the Legal Notice on the next page of this form. | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | Worker’s Signature | | | | | | | | | | | | | | | | | Date | | | | | | |
| 9. a. Has the worker ever been treated for the same or similar condition?  Select one. If YES, describe briefly or attach report. | | | | | | | | | | | | | | | | | | | | | | | |
| No  Yes | | | | | |  | | | | | | | | | | | | | | | | | |
| b. Is there any pre-existing impairment of the injured area?  Select one. If YES, describe briefly or attach report. | | | | | | | | | | | | | | | | | | | | | | | |
| 6. Referred for Diagnostic Studies  No  Yes, Specify | | | | | | | No  Yes | | | | | |  | | | | | | | | | | | | | | | | | |
| c. Are there any conditions that will prevent or retard recovery?  Select one. If YES, describe briefly or attach report. | | | | | | | | | | | | | | | | | | | | | | | |
| No  Yes | | | | | | |  | | | | | | | | | | | | | | | | |
| d. Was the diagnosed condition caused by this work injury or exposure on a more probable | | | | | | | | | | | | | | | | | | | | | | | |
| than not basis? (check one)  Yes  Probably (51% or more )  No  Possibly (Less than 50%) | | | | | | | | | | | | | | | | | | | | | | | |
| 10. a. Have you released this worker to return to regular work? | | | | | | | | | | | | | | | | | | | | | | | |
| No  Yes  effective date of return to work | | | | | | | | | | | | | | |  | | | | | | | | |
| 7. Treatment Recommendations | | | | | | | b. Have you released this worker to return to light duty? | | | | | | | | | | | | | | | | | | | | | | | |
| No  Yes  effective date of return to work | | | | | | | | | | | | | | |  | | | | | | | | |
| c. What restrictions are placed on light duty return to work? | | | | | | | | | | | | | | | | | | | | | | | |
| Lifting | | |  | | | | | | | | | | Bending | | |  | | | | | | | |
| Standing | | |  | | | | | | | | | | Sitting | | |  | | | | | | | |
| Other | | |  | | | | | | | | | | | | | | | | | | | | |
| d. If not released, how many days off work due to the work injury? | | | | | | | | | | | | | | | | | | | | | | | |
| Licensed Healthcare Provider must sign before report is accepted  11. Signature | | | | | | | | | | | | | | | | | | | | | | | **DO**  **NOT**  **SEND**  **THIS**  **FORM**  **TO**  **LABOR &**  **INDUSTRIES** |
| 12. Phone | | | | | | | | | | | | 13. Date | | | | | | | | | | |
| 8. Did you refer the patient to an L&I medical network provider for follow-up?  YES  NO Referred to: | | | | | | |
| 14. Attending Healthcare Provider Name | | | | | | | | | | | | | | | | | | | | | | |
| Address | | | | | | | 15. Address | | | | | | | | | | | | | | | | | | | | | | |
| Phone | | | | | | | City | | | | | | | | | | | State | | | ZIP | | | | | | | | |
| Distribution: Original-Employer, Copy-Worker, Copy–Provider **01-2014 version**  F207-028-000 **Check for updates – web address next page** | | | | | | | 16. L&I Provider Number or NPI | | | | | | | | | | | 17. IRS Account # | | | | | | | | | | | |

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| --- | --- |
| **WEB ADDRESS TO CHECK FOR UPDATES OF FORM:** [www.Lni.wa.gov/FormPub/Detail.asp?DocID=2467](http://www.lni.wa.gov/FormPub/Detail.asp?DocID=2467)  **NOTE:** Beginning Jan. 1, 2013, injured workers will need to get ongoing care from a medical provider who is part of the L&I Medical Provider Network. They may see a non-network provider for the initial visit, but for additional or ongoing care, they will need to transfer to a network provider.  **MAIL TO SELF-INSURED COMPANY**  1. If the worker brings this form to your office, this box may be pre-printed. If you initiate the form in your office, obtain information from the worker.  2. Have the worker complete this box or obtain information from the worker.  **ATTENDING HEALTH CARE PROVIDER INFORMATION**  **NOTICE: FAILURE TO FILE THIS REPORT WITHIN**  **5 DAYS FROM THE DATE OF TREATMENT MAY**  **RESULT IN A PENALTY OF $250 IN ACCORDANCE**  **WITH RCW 51.48.060.**  3. This exam date.  4. Date you first treated patient for this injury/condition.  a) Insert ICD Dx coding which corresponds to narrative  diagnosis in Box 3b.  b) Please list all diagnoses of conditions present which are result of incident or exposure. Also specify which side of body (right/left).  5. Indicate “Yes” or “No”. If “Yes”, list objective findings which support diagnosis. Do not restate diagnosis.  6. Indicate “Yes” or “No”. If “Yes”, specify study and complete findings if known.  7. Indicate treatment recommendations.  8. Specify name, address and phone number of health care provider to whom referred. Treatment beyond the initial visit must be done by providers enrolled in Washington’s workers compensation medical provider network. (This applies to workers of Self-Insured and State Fund employers.) Information to enroll in the network is available at JointheNetwork@Lni.wa.gov. If you choose not to enroll and your patient needs additional treatment, refer him or her to a network provider. The provider directory is available at www.Lni.wa.gov.  9. Indicate “Yes” or “No” and provide the additional information requested.  10. Indicate “Yes” or “No” and provide the additional information requested.  11. Signature of health care provider providing treatment and completing form. | 12. Health care provider’s phone number.  13. Date health care provider signs report    14. Print or type your name as it appears on your Department of Labor and Industries payee account.  15. Indicate your full mailing address.  16. Indicate your Department of Labor and Industries issued provider number or NPI.  17. Provide your Internal Revenue Service reporting account number.  **PATIENT INFORMATION**  1. Leave blank.  2. Name of injured worker.  3. Worker’s phone number.  4. Worker’s mailing address or street address.  5. Worker’s social security number.  6. City, state and ZIP code of worker’s address.  7. Date worker was born.  8. Date accident occurred.  9. Time accident occurred.  10. Dates the worker missed work due to this injury.  11. Indicate -- M = Male F = Female    12A. Marital/Registered Domestic Partnership Status, e.g.,  M = Married, S = Single, D = Divorced, DP = Registered Domestic Partnership.  12B. Dependents -Number of dependents under age 18 (does not  include spouse/domestic partner).  13. Brief description of accident or exposure by worker.  14. Medical Release Authorization. Worker’s signature authorizes  the release of relevant medical information.  15. Statement of Responsibility - I have reported or will report this incident or exposure to my employer. If my claim is denied, I understand that I will be responsible for the care provided to me.  **16. LEGAL NOTICE --RCW 51.48.020 (2) PROVIDES: ANY**  **PERSON CLAIMING BENEFITS UNDER THIS TITLE WHO**  **KNOWINGLY GIVES FALSE INFORMATION REQUIRED IN**  **ANY CLAIM OR APPLICATION UNDER THIS TITLE SHALL**  **BE GUILTY OF A FELONY, OR A GROSS MISDEMEANOR.** |