

IMPAIRMENT RATING DETERMINATION FACE SHEET

Bureau notification is performed by the examining physician's completion of the electronic version of this form in WCAIS.

| EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER | DATE OF INJURY WCAIS CLAIM NUMBER |
|---|--|
| | MM DD YYYY |
| EMPLOYEE | EMPLOYER |
| First name | Name |
| Last name | Address |
| Date of birth | Address |
| Address | City/Town State ZIP |
| Address | County |
| City/Town State ZIP | Telephone FEIN |
| County | INSURER or THIRD PARTY ADMINISTRATOR (if self-insured) |
| Telephone | — Name |
| ATTORNEY FOR EMPLOYEE (if known) | Address |
| Name | Address |
| Firm name | City/Town State ZIP |
| Address | County |
| Address | Telephone FEIN |
| City/Town State ZIP | NAIC code or Insurer code |
| Telephone PA Attorney ID number | Insurer/TPA claim # |
| ATTORNEY FOR INSURER/EMPLOYER (if known) | CLAIM REPRESENTATIVE |
| Name | Name |
| Firm name | Address |
| Address | Address |
| Address | City/Town State ZIP |
| City/Town State ZIP | Telephone FEIN |
| Telephone PA Attorney ID number | _ |

SEE IMPORTANT INFORMATION ON THE REVERSE

I examined the referenced employee,

impairment rating determination to define the degree of impairment due to the compensable injury, if any, in accordance with the provision of Section 306(a.3) of the Pennsylvania Workers' Compensation Act.

Attached is the Report of Medical Evaluation prepared as utilized by the American Medical Association Guides to the Evaluation of Permanent Impairment 6th edition (second printing April 2009).

The original of this face sheet and report is being provided to the Bureau of Workers' Compensation, Healthcare Services Review Division, 1171 S. Cameron Street, Harrisburg, PA 17104-2501, with copies to the employee, the employee's attorney (if known) and the insurer within 30 days of the date of the impairment evaluation.

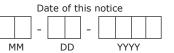
| Name of patient: | |
|----------------------------------|---|
| Social Security number: XXX-XX- | |
| Date of birth: | |
| Date of this examination: | |
| Percentage of impairment rating: | % |

My charge of \$ ______ will be billed to the Insurer or Third Party Administrator (if self-insured) for conducting this examination.

I attest that I am a physician in the Commonwealth of Pennsylvania and certified by an American Board of Medical Specialties approved board or its osteopathic equivalent, and that I have an active clinical practice of at least twenty (20) hours per week.

Physician

| Name | |
|-----------------------|-------|
| Address | |
| Address | |
| City/Town | _ ZIP |
| Telephone | |
| Federal Tax ID number | |
| NPI# | |
| Specialty | |
| Contact | |



Provider or Representative's signature

Provider or Representative's name (typed/printed)

Telephone

Email

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services 717.772.3702 Claims Information Services toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447 Hearing Impaired PA Relay 7-1-1 **Email** ra-li-bwc-helpline@pa.gov



Auxiliary aids and services are available upon request to individuals with disabilities. Equal Opportunity Employer/Program