Physician Information

To the Physician: If not provided, please contact the employer for a Physician Selection List for Referrals.

Medical Treatment & Work Status Form

Our dealership offers a Return-to-Work Program where we make every effort to promote expeditious recovery and transition back to the workplace.

Please complete the attached Medical Treatment & Work Status Form detailing work restrictions & return to Employee (or mail to PMA)

Billing & Payment

The PMA Companies will be responsible for making all compensability decisions regarding this workers compensation claim. If the claim is determined to be compensable all medical bills will be paid by PMA Companies under the VADA Group Self Insurance Association policy. Therefore, please forward all medical billings and medical reports directly to:

PMA Customer Service Center
PO Box 5231
Janesville, WI 53547-5231

Please reference the PMA Claim number or the employee's name, date of accident, & SSN

Note: All bills should be sent with appropriate supporting medical reports as they cannot be processed without the appropriate supporting medical reports

---

Questions? Contact PMA at 1-888-476-2669

Medical Treatment & Work Status Form

*Employee Name*_____ *Dealership*_____

To Be Completed By Healthcare Provider

(Please Note: A separate *Medical Treatment & Work Status Form* must be completed for each visit to an approved provider.)

Patient has follow up appointment on_____ ( ) Check if treatment complete

Diagnosis: _____

Treatment (including surgery, physical therapy, medications, and diagnostic procedures):

_____

_____

_____

Medical Recommendations for Return to Work: (Modified duty will be considered for all employees)

WORK STATUS: (Health Care Provider, please check all appropriate boxes)

[ ] Patient released to regular duty on _____ or, [ ] Patient expected to return to full duty on _____

[ ] Patient may work transitional/ modified duty as of _____with restrictions as listed below:

WORK EFFORT LEVEL: (US Dept of Labor Classifications, 3rd Ed. 1993)

[ ] Sedentary: lift/carry 10 lbs. maximum: walk, stand, sit as needed

[ ] Light: lift/carry occasional 20 lbs. maximum; sitting as needed, may lift/carry up to 10 lbs. frequently, walk stand, push, pull (arm or leg controls), may walk/stand to significant degree

[ ] Light Medium: lift/carry occasional 35 lbs. maximum, frequently lift/carry up to 20 lbs.

[ ] Medium: lift/carry occasional 50 lbs. maximum, frequently lift/carry up to 25 lbs.

[ ] Medium Heavy: lift/carry occasional 75 lbs. maximum, frequently lift/carry up to 50 lbs.

[ ] Other restrictions _____

[ ] Medium Heavy: lift/carry occasional 75 lbs. maximum, frequently lift/carry up to 50 lbs.

[ ] Heavy: lift/carry occasional 100 lbs. maximum, frequently lift/carry up to 50 lbs.

[ ] Employee can drive to work

[ ] No reaching above shoulder height

[ ] No reaching below waist

[ ] No exposure to dust/fumes

[ ] No operating vehicles

[ ] No operating machinery

Name of Healthcare Provider Practice _____ Phone _____

Signature of Healthcare Provider _____ Date _____

HEALTHCARE PROVIDER: *Please forward records and bills from this visit as soon as possible to: PMA – P. O. Box 2854 –Clinton, IA 52733-2854*
EMPLOYEE: *Return this form to your supervisor/claims coordinator*
QUESTIONS: *Contact PMA Management Corp. Customer Service:* 888-476-2669

To be Completed by Employee (Employee Signature Required)

Name: _____ SSN: _____ Date of Injury: _____ Phone: _____

Home Address:_____ City: _____ State: _____ Zip: _____

I give permission to my physicians or other healthcare providers, hospitals, or clinics to release the information on this form and to release my medical records relating to this injury/illness to my employer, PMA, and any entity responsible for providing services in connection with my workers' compensation claim. I understand this information will be used to assist my employer in evaluating my injury/illness, my work status, and proposed courses of treatment.

Employee Signature: _____ *Date:* _____

Transitional Duty Provided: _____ Date Transitional Duty Started: _____

Description of Transitional Duty: _____ Expected Completion Date: _____

To be Completed by Supervisor

Signature of Supervisor: _____ Date: _____