NEBRASKA WORKMEN'S COMPENSATION COURT

First Treatment Medical Report

(Must be filed with Compensation Court & Employer within 14 days of first treatment)

TYPE OR PRINT

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME *(First name, middle initial, last name)*	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME *(Employer)*
4. PATIENT'S ADDRESS *(Street, city, state, ZIP code)*	5. PATIENT'S SEX ☐ MALE ☐ FEMALE	6. INSURED'S I.D. NO. *(Include any letters)*
	7. PATIENT'S RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	8. INSURED'S GROUP NO. *(Or Group Name)*
9. OTHER HEALTH INSURANCE COVERAGE — Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO B. AN AUTO ACCIDENT ☐ YES ☐ NO	11. INSURED'S ADDRESS *(Street, city, state, ZIP code)*
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE *I Authorize ... any Medical Information to Process this ...* X *SIGNED* *DATE*		13. *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW* X *SIGNED (Insured or Authorized Person)*

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF:	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ YES ☐ NO
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM	THROUGH	DATES OF PARTIAL DISABILITY FROM / THROUGH
19. NAME OF REFERRING PHYSICIAN			20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED / DISCHARGED
NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*			22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? ☐ YES ☐ NO CHARGES:

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, ETC. OR DX CODE

1.
2.
3.
4.

24. A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE (IDENTIFY:)	*(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*	D DIAGNOSIS CODE	E CHARGES	F

24.A. HISTORY. GIVE BRIEF DESCRIPTION OF WHAT OCCURRED. PATIENT'S ACCOUNT OF ACCIDENT.

25. SIGNATURE OF PHYSICIAN OR SUPPLIER *(Read back before signing)* SIGNED DATE	26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) ☐ YES ☐ NO	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
32. YOUR PATIENT'S ACCOUNT NO.	30. YOUR SOCIAL SECURITY NO. / 33. YOUR EMPLOYER I.D. NO.	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO. I.D. NO.		

*PLACE OF SERVICE CODES

1—(IH) — INPATIENT HOSPITAL
2—(OH) — OUTPATIENT HOSPITAL
3—(O) — DOCTOR'S OFFICE
4—(H) — PATIENT'S HOME
5— DAY CARE FACILITY (PSY)
6— NIGHT CARE FACILITY (PSY)
7—(NH) — NURSING HOME
8—(SNF) — SKILLED NURSING FACILITY
9— AMBULANCE
O—(OL) — OTHER LOCATIONS
A—(IL) — INDEPENDENT LABORATORY
B— OTHER MEDICAL/SURGICAL FACILITY