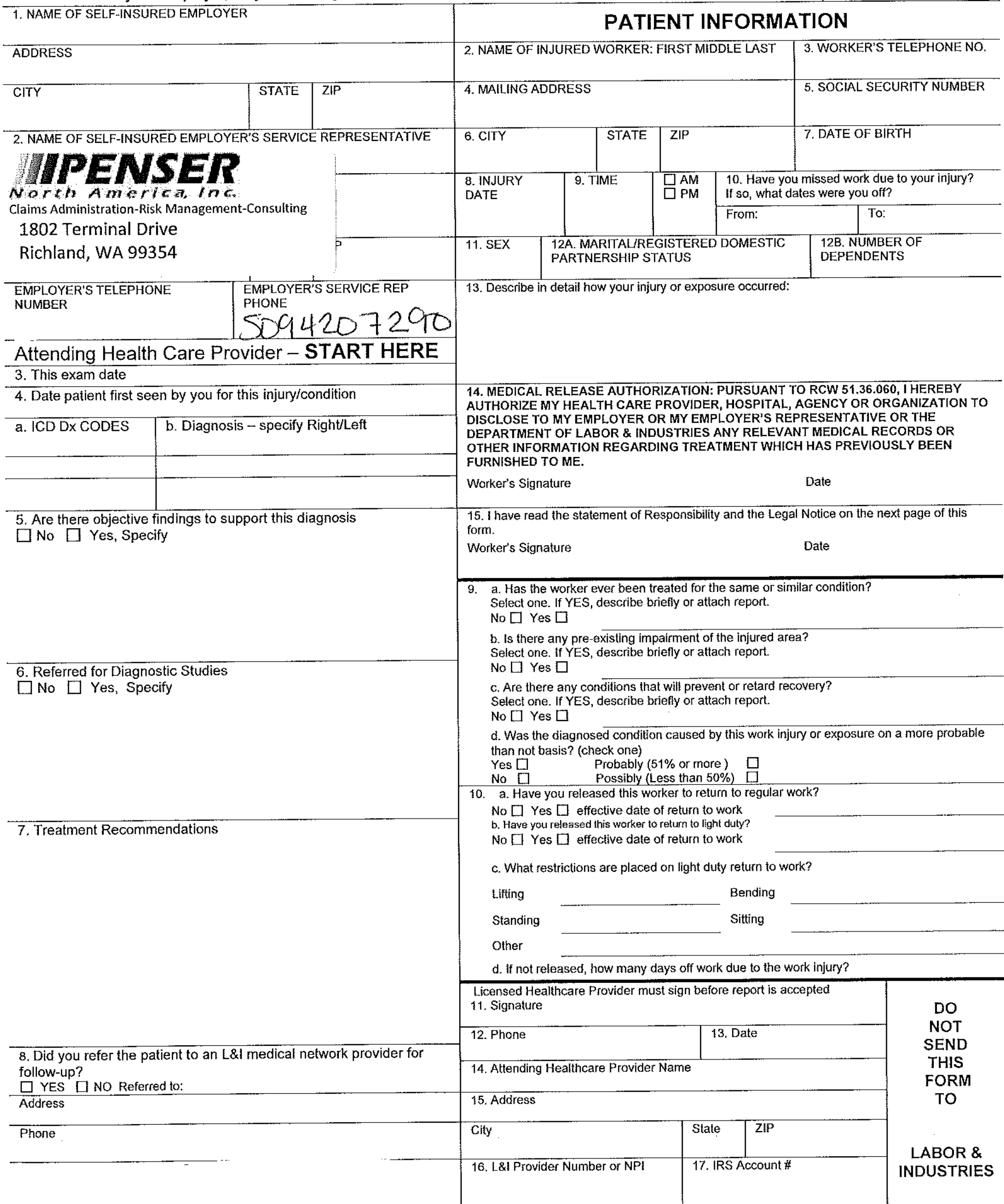
(Select one) Language Preference ☐ English ☐ Spanish ☐ Russian ☐ Korean ☐ Chinese ☐ Vietnamese ☐ Laotian ☐ Cambodian ☐ Other ____

PROVIDER'S INITIAL REPORT

MAIL TO SELF-INSURED COMPANY

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

ADDRESS

CITY | STATE | ZIP

2. NAME OF SELF-INSURED EMPLOYER'S SERVICE REPRESENTATIVE

IPENSER North America, Inc.
Claims Administration-Risk Management-Consulting
1802 Terminal Drive
Richland, WA 99354

EMPLOYER'S TELEPHONE NUMBER | EMPLOYER'S SERVICE REP PHONE 5094207290

Attending Health Care Provider – **START HERE**

3. This exam date

4. Date patient first seen by you for this injury/condition

a. ICD Dx CODES	b. Diagnosis – specify Right/Left

5. Are there objective findings to support this diagnosis
☐ No ☐ Yes, Specify

6. Referred for Diagnostic Studies
☐ No ☐ Yes, Specify

7. Treatment Recommendations

8. Did you refer the patient to an L&I medical network provider for follow-up?
☐ YES ☐ NO Referred to:
Address
Phone

PATIENT INFORMATION

2. NAME OF INJURED WORKER: FIRST MIDDLE LAST | 3. WORKER'S TELEPHONE NO.

4. MAILING ADDRESS | 5. SOCIAL SECURITY NUMBER

6. CITY | STATE | ZIP | 7. DATE OF BIRTH

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:

11. SEX | 12A. MARITAL/REGISTERED DOMESTIC PARTNERSHIP STATUS | 12B. NUMBER OF DEPENDENTS

13. Describe in detail how your injury or exposure occurred:

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.

Worker's Signature Date

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.
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

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

12. Phone | 13. Date

14. Attending Healthcare Provider Name

15. Address

City | State | ZIP

16. L&I Provider Number or NPI | 17. IRS Account #

DO NOT SEND THIS FORM TO LABOR & INDUSTRIES