



PARTNERSHIP FOR THE REVIEW AND INTEGRATION OF MEDICAL EXPENSE

TREATMENT REFERRAL FORM

TO BE COMPLETED BY EMPLOYER:

Date: _____

Medical Facility/Doctor: _____

Address: _____ Phone: _____

This authorization is issued to you to provide initial medical treatment to the employee names below who has reported an occupational injury.

Employee Name: _____ Social Security # _____

Date of injury: _____ Time of injury: _____ Occupation: _____

Type of injury: _____

Employer Name and Address: _____ Mendocino County Office of Education

Employee's Work Address: _____ 2240 Old River Road; Ukiah CA 95482

Workers' Compensation Administrator: KEENAN & ASSOCIATES

Employer Contact (Return-to-Work Coordinator or Supervisor):

Human Resources (Nancy Shaw/Donna Fennell) Phone: (707) 467-5012

Business Services (Katie Pearson) Phone: (707) 467-5033

INSTRUCTIONS TO PROVIDER:

- 1 Call the employer contact named above immediately to discuss availability of modified duty if the employee has any injury-related physical restrictions that may affect the employee's ability to return to full duty.
- 2 Send the original completed Doctor's First Report (DWC 5021) to KEENAN & ASSOCIATES at 1740 Technology Dr., Suite 300; San Jose CA 95110.
- 3 Contact KEENAN & ASSOCIATES at (408) 441-0754 immediately if any of the following apply:
 - Questionable injury
 - Diagnostic Imaging Request
 - Consultation Request
 - Surgery/Hospitalization Request
- 4 Send all medical bills and corresponding reports to KEENAN & ASSOCIATES at 1740 Technology Dr., Suite 300, San Jose CA 95110.