U.S. DEPARTMENT OF LABOR

EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT XX
LONDON, KY 40742-8300
Phone: (XXX) XXX-XXXX

DATE

Date of Injury:
Employee:

Dear Sir/Madam:

We are asking this employee to contact you for an appointment to determine the extent of permanent partial impairment of the due to the employment injury on the date above. The AMA Guides to the Evaluation of Permanent Impairment (Fifth Edition) is our standard for impairment rating purposes. Please examine this employee, provide the information requested on the attachment, and return the attachment along with this letter. The information will be used to determine eligibility for a schedule award.
To ensure timely payment, use the enclosed numbered billing Form OWCP-1500a and use the authorization number in corresponding with or calling the office about your bill. The form must contain the provider's signature in Block 25 and the tax identification number (Social Security Number or EIN) in Block 33. The medical report must accompany the bill to ensure prompt payment. Any bill submitted without a medical report will be held for its arrival, or returned. Payment will be made approximately thirty days from the receipt of these documents.

If the marked form is damaged and cannot be used, or if two forms are required, be sure to submit the bill on a standard American Medical Association Health Insurance Claim Form (OWCP-1500a/HCFA 1500) with your authorization number clearly marked in the upper right corner.

If you find it necessary to obtain a consultation with another specialist or to hospitalize the claimant in order to render a fully rationalized opinion, please contact the office at to obtain further authorization.

Sincerely,

Enclosure(s): OWCP-1500a,

OMB No. 1215-0103 Expires: 10-31-2008

NOTICE TO RECIPIENT

We estimate that it takes an average of 20 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, NW, Washington, DC 20210.

PRIVACY ACT

The authority for requesting the following information is 5 U.S.C. 8101 et. seq. The information will be used to determine entitlement to benefits. Furnishing the requested information is required to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974, as amended (5 U.S.C. 552a). Failure to furnish the requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.