OMB No: 1240-0046
Expiration Date: xx-xx-xxxx

U.S. DEPARTMENT OF LABOR

«SenderAddress»
Phone: «SenderPhone»

Date of Injury: «DtInjury»
Employee: «ClaimantFullName»

«ToAddress»

Dear «Salutation»:

«usr_OPTIONAL_PARAGRAPHS_1»

OPTION 1. We are referring «EMPLOYEE_NAME» to you for eye examination and evaluation of visual impairment. «EMPLOYEE_ NAME » being asked to contact you for an appointment.

At the conclusion of the examination, please submit a narrative report consisting of information identified in items 1 through 5 below.

OPTION 2. Our records show that «EMPLOYEE_NAME» may be continuing under your care for an injury on _____«Date of Injury».

We would appreciate receiving a detailed report on the progress and present status of «EMPLOYEE_NAME», including a discussion of the items listed below. If you wish first to reexamine the patient, please so advise and we will ask the patient to schedule an appointment with you.

1. The date of maximum improvement. If maximum improvement has not been reached, please state when it may be expected and your recommendations for further medical management, including the requirement for corrective lenses.

2. Current status of the injured eye. Indicate measurable defects to uncorrected vision, including central visual acuity, far and near; visual field constriction; ocular motility loss; and ability to fuse vision without glasses.

3. Present status of the uninjured eye (see above), including sympathetic involvement if present.

4. Any pathological condition observed in either eye.

5. Your recommendation of the percentage impairment of uncorrected vision on

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP.

the basis of your clinical findings and the AMA Guides to the Evaluation of Permanent Impairment (Sixth Edition).

If the injury has resulted in enucleation, the examination should include a careful study of the socket of the enucleated eye. Please indicate whether any disfigurement has resulted from the enucleation and give your recommendations as to the need for prosthesis, plastic surgery, or other treatment.

This information will be used to determine entitlement to benefits under the Federal Employees' Compensation Act.

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 this office at «usr_OFFICE_PHONE_NUMBER» to obtain further authorization.

To ensure timely payment, use the enclosed numbered billing Form OWCP-1500/HCFA 1500 and use the authorization number «usr_NUMERIC_AUTHORIZATION_NO» in corresponding with or calling the office about your bill.

The billing form must contain the provider's tax identification number (Social Security Number or EIN) in block 25 and the signature in Block 31. 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 30 days from 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-1500/HCFA 1500) with your authorization number clearly marked in the upper right corner.

Sincerely,

Federal Employees Program

Enclosure(s): OWCP-1500/HCFA 1500

«CCAddresses»

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Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to this collection of information unless it displays a currently valid OMB control number. Public reporting burden for this collection of information is estimated at 20 minutes to complete the collection of this information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is required to obtain or retain a benefit under 5 U.S.C. 8101, et seq. 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, and reference the OMB Control Number 1240-0046. Note: Please do not return the requested information to the address shown just above. Rather, send it to the address shown on the letterhead.

Privacy Act Statement

The Privacy Act of 1974 as amended (5 U. S.C. 552a) and the Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.), authorizes collection of this information. The information will be used in cases involving eye injury to determine the extent of loss of vision in complicated eye injury cases. Completion of this form is voluntary, however, failure to provide the information may result in the delay of processing of the claim or payment or benefits, or may result in an unfavorable decision or reduced levels of benefits. Additional disclosures of this information may be to: third parties in litigation; employing agencies, various individuals and organizations providing related medical rehabilitation and other services; insurance plans which may have paid related bills; labor unions; various law enforcement officials; other federal, state and local agencies (including the GAO and IRS) as appropriate; data processing contractors to the Department of Labor; debt collection agencies and credit bureaus."