WORKERS' COMPENSATION TREATMENT FORM

EMPLOYEE/CLIENT COMPANY INFORMATION

Employee's name: ____

Is being referred for treatment of a work-related injury which occurred on: ____________________

Supervisor's Signature ____________________________________ Date __________

Company Name ____

Address ____

Company Phone Number ____

EMPLOYEE AUTHORIZATION

This form authorizes the health care provider treating me to give Employers Resource Management, or their representatives, all information regarding my condition (either orally or in writing), while under your observation or treatment. This information may include history, findings, x-ray readings, diagnosis, and your prognosis as to subsequent or future development; and to photocopy such records as may be requested.

Employee Signature ____________________________________ Date ____/____/____

INFORMATION FOR HEALTH CARE PROVIDERS

Employers Resource Management is a co-employer with the company listed above. All Workers' Compensation questions should be referred to the Workers' Compensation Department at (208) 426-8006 or (800) 775-2404. Please speak slowly and repeat your number if you leave a voice mail message.

If you need pre-authorization, or have questions regarding billing, please contact the number below:

Zurich American Insurance Company
Schaumburg- Home Office Claims
PO Box 66946
Chicago, IL 60666-1946
Phone No.: 800-525-2251
Fax: 847-605-7616

1301 South Vista Avenue • Boise, Idaho 83705 • (208) 426-8006 • (800) 775-2404 • Fax (866) 214-9505
Email • workcomp@employersresource.com