EMPLOYERS®

Workers' Compensation Temporary Treatment ID Form

This is a temporary workers' compensation program ID form.
This form is not a guarantee of eligibility for workers' compensation benefits.

TO BE FILLED OUT BY EMPLOYER

Please Print

EMPLOYER NAME:

EMPLOYER CONTACT:

PHONE #: ( ) POLICY #:

DATE OF INJURY:

EMPLOYEE NAME:

SOCIAL SECURITY NUMBER:

LOCATION OF INJURY:

BODY PART(S) INJURED:

A DRUG TEST IS REQUIRED AT THE TIME OF TREATMENT
(Please include the following information or attach a Chain of Custody form)

TYPE OF TEST: ALCOHOL: Yes

SEND DRUG TEST RESULTS & INVOICE TO *(Employer address)*:

Light/Modified Duty - Available for Release to Return to Work

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EMPLOYERS CONTACT INFORMATION FOR MEDICAL PROVIDERS:

- Please call 800-992-1072 with any treatment authorization questions.
- Invoices should be mailed to:
  Bunch Care Solutions
  PO Box 14792
  Lexington KY 40512-4792
  Phone: 888-853-4735 Option 6
  Fax: 863-669-2071
  billinginquiries@bunchcare.com

Pharmacy/Prescriptions: Contact Tmesys/Optum at 1-800-964-2531