MISSOURI UNIVERSITY OF SCIENCE AND TECHNOLOGY
WORKERS' COMPENSATION REFERRAL FOR MEDICAL CARE

Patient Name:_____ Date/Time of Injury:_____

Department/Contact Person:_____ Phone:_____

Type of Injury/Illness:_____

_____

_____
Authorized Signature

Facility:_____

_____

TO BE COMPLETED BY ATTENDING THERAPIST

Date(s) of Therapy:_____

Treatment Rendered:_____

_____

_____

Shows Improvement: ☐ Yes ☐ No

Next Appointment Date/s:_____

Referrals For Specialist, PT, or diagnostic testing other than x-rays: call Corporate Claims at 1-800-449-2264

_____
Therapist's Signature

Original - Return to Missouri S&T; Copy - Physician; Physician, please FAX to Corporate Claims at 636-519-7572

All bills for these services to be submitted to:

Corporate Claims Management, Inc.
770 Spirit 40 Park
Chesterfield, MO 63005