

Notice to Medical Providers

Production/Event Employer: Please complete the following and fax to the physician prior to the first medical treatment visit for an employee's work-related injury/illness.

Note to Physician/Medical Provider: The injured worker listed below has been referred to your office for initial medical treatment of an injury/illness that may be work-related. Sedgwick is the administrator for Workers' Compensation claims. **Please note that a claims examiner from Sedgwick must approve any non-emergency treatment following this visit.**

Employee

Name: _____

SSN: _____

Date of Injury: _____

Occupation: _____

Incident Location: _____

Body Part(s) Injured: _____

Employer/Supervisor Signature: _____

Production/Event Company

Production/Event Name: _____

Project/Event Name: _____

Contact Name: _____

Title: _____

Phone: _____

Today's date: _____

Submit medical invoices to: Sedgwick
P.O.Box 14440 Lexington, KY 40512-4440

Submit work status' to: Cast & Crew
2300 W. Empire, 5th Floor Burbank, CA
91504 Ph: 818.738.9351 / Fax:
818.848.4614
workcomp@CastandCrew.com

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Return to Work Report

Must be completed immediately after any doctor evaluation and/or visit, sent with employee and same day emailed to workcomp@castandcrew.com or faxed to 818.848.4614

Name of Clinic:

Clinic Address: Employee

Clinic Phone Number:

Employee Name:

Date of Birth:

Date of Injury:

Body Part: _____

Diagnosis: _____

Treatment Plan: _____

Can employee return to work? Yes No

If Yes: Return to work date: _____

If No: Anticipated return to work date: _____

Restrictions:

Full duty without restrictions

Modified work (select all applicable below)

Lift Not At All 5-10 lbs 15-25 lbs 30-50 lbs

Carry Not At All 5-10 lbs 15-25 lbs 30-50 lbs

Push/Pull Not At All 5-10 lbs 15-25 lbs 30-50 lbs

Bend Not At All Up to ___ hours/day

Kneel Not At All Up to ___ hours/day

Reach Not At All Up to ___ hours/day

Twist Not At All Up to ___ hours/day

Grasp Not At All Up to ___ hours/day

Stand/Walk Not At All Up to ___ hours/day

Sit Not At All Sedentary Work Only

Restrictions Affect: Left Extremity Right Extremity Both Extremities

Must use DME: None Crutches Splint Back Brace Other _____
(Durable Medical Equipment)

Laceration – Must keep wound clean and dry. Change dressing daily.

Other restrictions: _____

Physician comments:

Next Appointment: _____
(Date/Time) (Physician Name) (Specialty)

Medical Provider Billing Information

Injured Employee: Please provide this sheet to all medical providers providing treatment for your injury.

Important Instructions to Medical Providers

1. The injured worker has been referred to your office for medical treatment of an injury/illness that may be work-related. Sedgwick is the workers' compensation third party administrator (TPA) for Cast & Crew Entertainment. Please note that a Claims Examiner from Sedgwick must approve any non-emergency treatment following this initial visit. Payment for work-related medical services is **NOT** the patient's responsibility, so please **DO NOT SEND BILLS TO THE INJURED EMPLOYEE.**
2. For medical services requiring authorization or additional claims information questions please contact the appropriate Sedgwick office. A full list by State is on the back side of this sheet.
3. For payment, medical reports must be attached to the medical invoices for consideration of payment. Medical invoices need to be submitted on a HCFA 1500 or UB92 with valid diagnosis and CPT codes.
4. Please provide a Date of Injury, SSN, and DOB of the injured employee on the medical invoice.
5. Please submit all itemized medical invoices via mail, email, or fax to:

Sedgwick
PO BOX 14442 Lexington, KY 40512-4442
Email: candcintakedoc@sedgwickcms.com (max size 30MB)
Fax: 833-875-6679 (this fax number can also be used for Utilization Review requests)
6. Submit work status' (return to work full duty, modified duty, restrictions, etc.) to:

Cast & Crew Entertainment
2300 W. Empire, 5th Floor, Burbank, CA 91504
Phone: (818) 848-6022 | Fax: (818) 848-4614
Email: workcomp@CastandCrew.com
7. Lastly, we value our relationship with medical providers and appreciate the quality medical services provided. We strive to provide timely payment reimbursement for medical services, so please adhere to the instructions above so there are no delays in payment. For payment status inquiries contact EK Health Provider Inquires at 888-507-0616 or email ProviderInquiry@ekhealth.com

This does not guarantee that benefits will be payable under Workers' Compensation coverage. Benefit payments are always subject to a determination by the Sedgwick Claims Examiner at the time the service was rendered.

Sedgwick contact phone numbers by State:

AK.....	(800) 906-3147
CA.....	(800) 731-1005
CO	(800) 507-9656
FL, GA, KY, MS, NC, SC.....	(800) 548-1373
HI	(866) 580-6674
ID, UT	(866) 253-1074
IL, MI, MN, NE, WI, MO	(800) 358-2072
DC, DE, MD, NJ, PA, VA, ME.....	(800) 285-3258
CT, MA, NH, RI, VT	(800) 526-3721
IN, IA, SD.....	(800) 358-2072
MT.....	(866) 458-4737
KS.....	(800) 358-2072
NM	(800) 255-4349
NV.....	(702) 568-3740
NY.....	(315) 426-4800
OR	(800) 906-3147
LA, OK, TX.....	(972) 372-6100
AL, AR, TN, WV.....	(877) 925-5580

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