

Authorization for Examination
And/Or Treatment

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



The following request for information is required under (5 USC 8101 et. seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir. No. A-108.

OMB No.: 1215-0103
Expires: 9-30-2011

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service:

**Primary Care Medical Center
1000 South 12th St
Murray, KY 42071**

2. Employee's Name (last, first, middle)

Bear, Smokey

3. Date of Injury (mo. day, yr.)

07/07/2009

4. Occupation

Forestry tech

5. Description of Injury or Disease:

Rolled right ankle

6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 11, subject to the condition stated in item A, and to the condition indicated either 1 or 2, in item B.

A. Your signature in item 35 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services.

B. 1. Furnish office and/or hospital treatment as medically necessary for the effects of this injury. Any surgery other than emergency must have prior OWCP approval.

2. There is doubt whether the employee's condition is caused by an injury sustained in the performance of duty, or is otherwise related to the employment. You are authorized to examine the employee using indicated non-surgical diagnostic studies, and promptly advise the undersigned whether you believe the condition is due to the alleged injury or to any circumstances of the employment. Pending further advice you may provide necessary conservative treatment if you believe the condition may be to the injury or to the employment.

7. If a Disease or Illness is Involved, OWCP Approval for Issuing Authorization was obtained from: (Type Name and Title of OWCP Official)

8. Signature of Authorizing Official:

9. Name and Title of Authorizing Official: (Type or print clearly)
**XXXXXXXXXXXXXXXXXX
Comp/claims Specialist**

10. Local Employing Agency Telephone Number:
(XXX)XXX-XXXX

11. Date (mo., day, year)

07/07/2009

12. Send one copy of your report: (Fill in remainder of address)

**U.S. DEPARTMENT OF LABOR
Office of Workers' Compensation Programs
Dallas District Office
525 South Griffin Street, Room 100
Dallas, TX 75202**

Please refer to the Interagency Incident Business Management Handbook Chapter 10, Section 15 for a complete list of DOL District Offices

13. Name and Address of Employee's Place of Employment:

Department of Agency

US Forest Service

Bureau or Office

**Albuquerque Service Center (ASC-HRM)
Annex WC**

Local Address (including ZIP Code)

**3900 Masthead Street NE
Albuquerque, NM 87109**

Public Burden Statement

We estimate that it will take an average of 5 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Form CA-16
Rev. Feb. 2005

PART B - ATTENDING PHYSICIAN'S REPORT

14. Employee's Name (Last, first, middle)

Bear, Smokey

15. What History of Injury or Disease Did Employee Give You?

16. Is there any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment?
(If yes, please describe)

Yes No

16a. IDC-9 Code

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17. What are Your Findings? (Include results of X-rays, laboratory tests, etc.)

18. What is Your Diagnosis?

18a. IDC-9 Code

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19. Do You Believe the Condition Found was Caused or Aggravated by the Employment Activity Described? (Please explain your answer if there is doubt)

Yes No

20. Did Injury Require Hospitalization?

Yes No

If yes, date of admission (mo., day, year)

Date of discharge (mo., day, year)

21. Is Additional Hospitalization Required?

Yes No

22. Surgery (If any, describe type)

23. Date Surgery Performed (mo., day, year)

24. What (Other) Type of Treatment Did You Provide?

25. What Permanent Effects, If Any, Do You Anticipate?

26. Date of First Examination (mo., day, year)

27. Date(s) of Treatment (mo., day, year)

28. Date of Discharge from Treatment (mo., day, year)

29. Period of Disability (mo., day, year) (If termination date unknown, so indicate)

Total Disability: From To
Partial Disability: From To

30. Is Employee Able to Resume

Light Work
 Regular Work

Date:
Date:

31. If Employee is Able to Resume Work, Has He/She been Advised?

Yes No

If Yes, Furnish Date Advised

32. If Employee is Able to Resume Only Light Work, Indicate the Extent of Physical Limitations and the Type of Work that Could Reasonably be Performed with these Limitations.

33. General Remarks and Recommendations for Future Care, if Indicated. If you have made a Referral to Another Physician or to a Medical Facility, Provide Name and Address.

34. Do You Specialize? Yes No (If yes, state specialty)

35. SIGNATURE OF PHYSICIAN. I certify that all statements in response to the questions asked in Part B of this form are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

36. Address (No., Street, City, State, ZIP Code)

37. Tax Identification Number

39. Date of Report

38. National Provider System Number

MEDICAL BILL: Charges for your services should be presented to the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500a, or HCFA 1500). Service must be itemized by Current Procedural Terminology Code (CPT 4) and the form must be signed.

INFORMATION FOR PHYSICIAN

YOUR AUTHORIZATION

- Please read Part A of Form CA-16. You are authorized to examine and provide treatment for the injury or disease described in Item 5, for a period of not more than 60 days from the date of issuance, subject to the conditions in Item 6. A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee. Authorization may be terminated earlier upon written notice from OWCP. For extension of the authorization to treat beyond the 60 day period, apply to the office shown in Part A, Item 12.

This form covers office visits and consultations, laboratory work, hospital services (including inpatient), x-rays, MRIs, CT Scans, physical therapy, emergency services (including surgery) and chiropractic services. Chiropractic services are limited to charges for physical examinations and x-rays to diagnose a subluxation of the spine and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by x-ray.

This form does not cover elective and non-emergency surgery, home exercise equipment, whirlpools, mattresses, spa/gym memberships and work hardening programs.

USE OF CONSULTANTS AND HOSPITALS

- You may utilize consultants, laboratories and local hospitals, if needed. Authorize semi-private accommodations unless a private room is medically necessary. Ancillary treatment may be provided to a hospitalized employee as necessary.

REPORTS

- After examination, complete items 14 through 39, of Part B, and send your report, together with any additional narrative or explanatory material, to the address listed in Part A, item 12. If the employee sustained a traumatic injury and is disabled for work, reports on Form CA-17, "Duty Status Report" may be required by the employing agency during the first 45 days of disability. If disability continues beyond 45 days, monthly reports should be submitted. Reports from all consultants are also required. Delay in submitting medical reports may delay payment of benefits.

RELEASE OF RECORDS

- Injury reports are the official records of OWCP. They shall not be released to anyone nor may any other use be made of them without the approval of OWCP.

BILLING FOR SERVICES

- OWCP requires that charges be itemized using the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500, or HCFA-1500). Each procedure must be identified, in Column 24 C of the form, by the applicable Current Procedural Terminology (0 editor) Code (CPT 4). A copy of the form may be supplied by the employee at the time treatment is sought.
- Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

TAX IDENTIFICATION NUMBER

- The provider's Tax Identification Number (TIN) is an important identifier in the OWCP system. To speed processing and to reduce inaccuracy of payment, the provider's TIN (Employer Identification Number or SSN) should be shown on all reports and billings submitted to OWCP. If possible, providers should decide on a single TIN - either corporate or personal - which is used consistently on OWCP claims.

ADDITIONAL INFORMATION

- Contact the OWCP shown in Item 12 of Part A.

Please Remove These Instructions Before Submitting Your Report.