IWIF Workers' Compensation Insurance
AccidentLeave@iwif.com
FAX: 410-339-4061
PO Box 9899
Towson, MD 21284-9899

ACCIDENT LEAVE REQUEST-MEDICAL TREATMENT VERIFICATION

You are entitled to accident leave for medical treatment resulting from your work related injury. Complete appropriate boxes below, sign and date form and send to IWIF at the fax, e-mail or address noted. Copies of supporting documents should be attached (i.e. activity status reports, doctors/disability slips). This form may be photocopied as necessary. You should keep a copy for your records.

Accident Leave Request- Medical Treatment Verification

EMPLOYEE: _____ DOB ___/___/_____
CLAIM NUMBER: _____ EMPLOYEE PHONE NUMBER:____-____-____
STATE OF MD AGENCY: _____

VISIT INFORMATION: Type: Office Visit (OV), Physical Therapy (PT), Diagnostic Testing (D), Other (O)

DATE	PROVIDER NAME/PHONE/FAX	TYPE	HOURS	SIGNATURE/STAMP

EMPLOYEE SIGNATURE: _____ DATE: _____
HOURS REQUESTED: _____

ADJUSTER: _____ E-MAIL: _____ PHONE: ___-____-____