Verification of Employment for a Reported Workers' Compensation Injury or Illness

Please take this form to the doctor for your first medical examination.

Employee Name_____Date of Injury _____

Date of Birth_____Social Security _____

Reported Work Related Injury or Illness:

_____

_____

_____(member organization) workers' compensation coverage provider is the Texas Association of School Boards Risk Management Fund which is a member of the Political Subdivision Workers' Compensation Alliance (the Alliance.) For emergencies, an injured employee may go tothe nearest emergency room. Otherwise, all other treatment must be from an Alliance Provider listed at pswca.org.

Please submit all claim and medical billing information to:

TASB
P.O. Box 2983
Clinton, IA 52733-2983
Phone: 800.732.0153
Fax: 732.212.7009

eBill Information
Clearinghouse: WorkComp EDI
Clearinghouse website: www.workcompedi.com
TASB's Payer ID: WR902

Pre-Authorization
Phone: 800.482.7276, x9907
Fax: 888.777.8272

Issuing Signature_____ Title _____

Phone Number_____ Date _____

Providers please submit Work Status Reports and all Job Description inquiries to:

Contact Name, Title

Phone

Fax

Email

For a full list of Alliance Providers please visit pswca.org.