FORESIGHT

Workers Comp Medical Service Referral

Employer – complete and sign this form and give to the employee.
Employee- give the completed form to the clinic/physician

Doctor / Clinic Name: _____

Doctor / Clinic Address: _____

We are sending our employee named _____ to you for an evaluation and

treatment relative to an injury sustained on the following date: _____

Please note: *We have a transitional return to work program available for the injured employee. All injuries will be considered for modified work duties.*

Broadspire
A CRAWFORD COMPANY

U.S. Mail address for paper bills:
Broadspire
PO Box 14645
Lexington, KY 40512

Electronic bills (EDI formatted - for providers that inquire about this):
To route electronic bills to Broadspire, please utilize Payer ID TP021

Our e-billing Agent is Ingenix

Fax number: 855-429-1483 (Note: this Fax number is not for customer service)

Employer Name (Print): _____

Signature: _____

Employer Title: _____

Phone Number: _____