Boston University Occupational Health Center
930 Commonwealth Avenue
Boston, Massachusetts 02215
T 617-353-6630 F 844-537-3577
injury@bu.edu

Initial Assessment/Treatment Claim Form

Attention: This Boston University Employee is reporting a work related condition.

Name: _____ DOB: _____

Mobile Phone: _____ BUID: _____

Home Address: _____

Temporary Claim number: **19N09FNC**

I hereby authorize any clinician or hospital in which I have been treated or examined to furnish Boston University and its Workers Compensation Administrator with a full report regarding my medical condition related to this reported work incident/accident. This release allows the bearer to examine and obtain copies of all these specific medical records and reports for determining eligibility for workers compensation.

Employee's Signature: _____ **Date:** _____

Billing Instructions for urgent and emergency treating center/provider. Fax or mail the following documentation to: CCMSI, Workers Compensation Administrator for Boston University

1. This Initial Assessment/Treatment Claim form
2. All documentation of treatment and testing and provider narratives
3. Itemized invoice (HCFA or UB)

CCMSI
55 Walkers Brook Drive, Suite 402
Reading, MA 01867
Phone: 800-552-1150 **Fax:** 781-246-3425

Employee Instructions: Submit this document to any provider you see for this work injury to ensure proper billing

- Complete shaded section above
- Sign and date authorization
- Copy this form, keep the copy for your records
- Contact Boston University Occupational Health Center

Boston University Occupational Health Center
Ph: 617-353-6630
Fax: 844-537-3577
Email: injury@bu.edu
Nurse Case Manager: Ruth Landau-Hoffeld, NP