encova INSURANCE

ATTENDING PHYSICIAN'S REPORT

Return completed form to:
Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151
Or fax to: 877-898-6980

Claim number	Social Security number
DOI	Phone number
Claimant name	Current address
Has your address changed? ☐ Yes ☐ No	Has your phone number changed? ☐ Yes ☐ No
If yes to either, please enter the new address or phone number.	

1. Date of examination	2. Date of next appointment
3. Accepted diagnosis code(s)	Additional request diagnosis code(s) (please attach justification)
4. Claimant occupation	

5. Treatment plan information (please include medication, consultations, complicating conditions, subjective complaints, objective findings)
Please attach treatment notes, if available.

Has an FCE been scheduled? ☐ Yes ☐ No	IME recommended? ☐ Yes ☐ No	Anticipated MMI date

6. Please indicate which of these activities the claimant **CAN** perform

Sitting ☐ Yes ☐ No	Kneeling ☐ Yes ☐ No	Reaching ☐ Yes ☐ No
Standing ☐ Yes ☐ No	Twisting ☐ Yes ☐ No	Bending ☐ Yes ☐ No
Walking ☐ Yes ☐ No	Driving ☐ Yes ☐ No	Climbing ☐ Yes ☐ No

7. Restrictions limited to

8. Dates claimant is certified temporarily and totally disabled due to compensable injury From To

Estimated trial RTW date	Modified duty RTW date

9. Physician legal signature	Physician printed signature	Date
Physician address	I certify this document has been discussed with me and I understand the treatment plan and work restrictions. I ☐ have ☐ have not received any income for any work during the time I have been certified temporarily and totally disabled. I hereby certify that the statements and answers set forth above are truth and correct to the best of my knowledge and belief. I am aware that the law provides severe penalties if I knowingly and with fraudulent intent withhold a material fact or make false statements in order to obtain or increase a benefit to which I am not entitled.	
10. Claimant signature	Claimant printed name	Date

INSTRUCTIONS FOR BI-219

1. Date the treating physician treated/actually had face-to-face contact with the claimant regarding the compensable injury. This should be mm/dd/yyyy.
2. The next date the treating physician is scheduled to treat the claimant face to face for the compensable injury. This should be mm/dd/yyyy.
3. Treating physician will need to complete. Diagnosis code(s) must relate to the mechanism of injury and compensable diagnosis. If additional diagnosis codes are being requested, the BI-214 must be completed.
4. Claimant's current occupation.
5. Treatment plan box must be completed in addition to any attachments regarding treatment. These notes must include claimant's subjective complaints, objective findings, the current assessment, and the treatment plan (detailed). It should also indicate if an FCE is warranted, an IME recommended, and anticipated MMI date.
6. Please mark yes or no on activities claimant is physically able to perform with regard to the compensable diagnosis.
7. What physical limitations does the claimant have based only on the compensable injury? Please be specific.
8. This must indicate specific dates. "Unknown" or "indefinite" is not acceptable and will cause a delay in temporary total benefits. Temporarily and totally disabled is defined as being unable to perform any activities associated with the covered employment. Estimated trial return to work date is the date claimant is medically released to attempt full duty work with the pre-injury employer in the pre-injury job. Modified return-to-work date is the date claimant may attempt to return to work with physician-approved modifications.
9. This is the physician's signature and the physician's printed name (must be legible). Disability dates must be certified by the treating physician only. Physician's assistants and nurse practitioners may not certify disability.
10. Claimant must sign form which indicates he agrees with the treatment plan and he has not received any other wages during the dates of disability certified by the treating physician.

NOTE: If claimant has reached maximum degree of medical improvement, please complete form BI-219a, Notice of Maximum Medical Improvement.