N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
VOCATIONAL REHABILITATION

REHABILITATION INDIVIDUAL WORKERS' COMPENSATION MEDICAL AUTHORIZATION

PROCEDURES

Fill out form completely.
Give the injured individual the form to take to the medical provider.
Contact the Agency's Workers' Compensation Administrator immediately.

MEDICAL PROVIDER: Workers' Compensation Carrier

LIBERTY MUTUAL GROUP
WC1-35S-323465-010
P. O. Box 25333
Charlotte, NC 28229-5333

Phone: (800) 532-7706
Fax: (704) 365-4379

Name of Individual

Last: _____ **First**: _____

Social Security Number: _____

Date of Injury: _____

Authorized By: _____ Date: _____
(Authorized Signature Required)

North Carolina Department of Health and Human Services
Division of Services for the Blind

INJURED INDIVIDUAL SHOULD TAKE THIS FORM TO THE MEDICAL PROVIDER

EMPLOYER/REHABILITATION STAFF: Complete this form and give to the injured individual before a doctor is seen.

MEDICAL PROVIDER: When a referral is necessary, please call carrier to advise that a referral is being made (1-800-532-7706, ext. 351)