WORKERS' COMPENSATION TREATMENT REFERRAL

FARMERS INSURANCE

To be completed by Supervisor		Date	
Medical Facility/Doctor		Phone ( )	
Address	City	State	ZIP
Employee Name		Soc. Sec. No.	
Occupation	Date of Injury	Time of Injury AM/PM	
Employer Name		Phone ( )	
Address	City	State	ZIP
Supervisor Authorizing Treatment			

Instructions to Medical Facility/Doctor

This authorization is issued to you to provide ***initial*** medical treatment to the employee named above who has reported an occupational injury.

1. Call the supervisor named above immediately if the employee cannot return to work (full or modified duty).
2. Send the original completed doctor's first report to Farmers Claim Services:
   - **Mail the first report of injury to:**
     Farmers WC Imaging Center
     P.O. Box 108843
     Oklahoma City, OK 73101-8843
   - **Telephone Number**
     (866) 967-5256
   - **Fax Number**
     (866)
     846-3114
   - **E-mail**
     wcclaimsdocs@farmersinsurance.com
   - **On-Line**
     farmers.com

For use in: AL, AR, CA, IL, IN, IA, KS, MI, MN, MO, OK, TN, VA and WI