encova INSURANCE

# NOTICE OF MAXIMUM MEDICAL IMPROVEMENT

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

**TO BE COMPLETED BY THE AUTHORIZED TREATING PHYSICIAN UPON THE CLAIMANT OBTAINING MAXIMUM MEDICAL IMPROVEMENT.**

COMPLETE ALL OF THE QUESTIONS. PLEASE PRINT OR TYPE.

| | |
|---|---|
| 1. Claimant name and address | 2. Claim number<br>Social Security number<br>DOI |
| 3. Are you the claimant's authorized treating physician in this claim? ☐ Yes ☐ No | |
| 4. Diagnosis code | |
| 5. Is further treatment necessary? ☐ Yes ☐ No<br>If yes, please list the type of treatment required. | |
| 6. Claimant was/will be able to return to work on (date) | |
| 7. Has claimant reached a maximum degree of medical improvement in relation to this injury? ☐ Yes ☐ No | |
| 8. Is there a permanent partial disability as a result of this injury? ☐ Yes ☐ No | If yes, please give your opinion of the degree of permanent partial disability in terms of percentage of whole man. % |
| 9. Is any part of the permanent disability listed under Question 8 due to causes other than this injury? ☐ Yes ☐ No<br>If yes, please allocate any disabilities resulting from prior claims and noncompensable injuries and/or disease processes. | |
| 10. If you have recommended a percentage of permanent partial disability (question 8), please list the physical findings on which the assessment was made including any restrictions on the claimant's functional abilities.<br>A narrative report should be attached if indicated. | |
| 11. Date of examination upon which these findings are based | |
| 12. Physician name<br>Physician phone number | Physician address |
| FEIN | |
| Physician signature | Date |