

**DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES**

**VERIFICATION OF MEDICAL APPOINTMENT FORM**

**This form must be completed by the Medical Service Provider**

Employees must take this form to each workers' compensation medical appointment made during or after their regular working hours. The employee's time sheet should be coded "WSPC" for the time it takes the employee to travel to the appointment, while they are at the appointment, and the time it takes the employee to return to work.

Employees' will be paid only for the time at the appointment when the appointment is after work hours, or on scheduled days off. Payment for these appointments will be paid through the Third Party Administrator, and not through payroll.

This form **must** be attached to the corresponding time sheet, or faxed to the Departments Workers' Compensation Unit. (Fax # 860-262-5011)

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**Employee Name:** \_\_\_\_\_

**Medical Service Provider:** \_\_\_\_\_

**Appointment Date:** \_\_\_\_\_ **Appointment Start Time:** \_\_\_\_\_

**Appointment End Time :** \_\_\_\_\_

**Is this appointment due to a work related injury/illness?**     **yes**     **no**

\_\_\_\_\_  
**Medical Service Provider Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Address**

**Town,**

**State**