

ACKNOWLEDGEMENT OF RECEIPT
Receipt of Employee Claim Form (DWC-1)

Employer Representative Instructions: Use this form to document each time you provide a DWC-1 to an injured worker. Provide injured worker with current Approved WC doctor list. Provide a signed copy to Human Resources, Workers' Compensation.

Injured Worker: Sign and return this form to the employer representative when a DWC-1 is provided to you.

I received a Workers' Compensation Claim form DWC-1

Injured Worker Printed Name: _____

Signature: _____

Date: _____

Time: _____

Employer Representative Printed Name: _____

Signature _____

Date: _____

MEDICAL REFERRAL FORM

The following covered injured worker: _____
seeks treatment for their industrial injury.

Please submit all billing to Placer County's Workers' Compensation third party administrator:

Intercare Holdings Insurance Services, Inc.
P.O. Box 579
Roseville, CA 95661
Phone (916) 677-2103
Fax (916) 781-5631

Employer:
Placer County Human Resources-Workers' Compensation
145 Fulweiler Avenue, Suite 200
Auburn, CA 95603
Phone: (530) 886-2611 or (530) 886-2606
Fax: (530) 886-4609