ORU

WORKERS' COMPENSATION REFERRAL

Dear Medical Provider:

Please be advised the following employee is authorized to receive initial care for an injury or illness the employee reports having received on-the-job for Oral Roberts University. The incident will be investigated. This authorization is not an admission of liability or compensability under the Oklahoma Workers' Compensation Act.

Name of Employee: _____

Social Security Number: _____

Authorized by: _____
Immediate Supervisor or Departmental Manager

Department: _____

Phone: _____

Date: _____

Policy # WCV041228002
BancInsure, Inc.

Send claims to:

Claims & Risk Services
P.O. Box 21450
Oklahoma City, OK 73156
800 725-0943

405 751-0943
800 725-0943

If you have any questions, you may contact Risk Management at:

918.495.7560
918.495.7563 *fax*