WCP - 8

WORKERS COMPENSATION FUND
APPLICATION FOR APPROVAL OF HEALTH CARE SERVICES

(Note: This form shall be filled in duplicate by accredited health care/service provider)

1. PARTICULARS OF THE HEALTH CARE/SERVICE PROVIDER

Name of health care/service provider……....
Contact address……..……
Tel ……Fax…….WCF accreditation No. (if available)..……..

2. EMPLOYEE'S PARTICULARS

First Name…… Middle Name …….Last Name …….....
Employee's code No. ……National ID No……..…… Employee's ID No …….
Date of birth ……Sex……Marital status…….....
Contact address…….. Street/Village …….. District……
Region……..……...
Name of employer…….……..

3. PARTICULARS OF SERVICE (S) APPLIDED FOR APPROVAL

i. Diagnosis.....
ii. Service (s) applied for.....
iii. Reasons for application of service (s).....
.....
.....

(Note: Attach relevant medical document (s) to support the application for the approval of services)

DECLARATION

I hereby certify that to the best of my knowledge all particulars in this application are true and correct.
Name……..
Designation……Signature…….
Date……..… Official Stamp

WCF OFFICIAL USE

I, ……., hereby approve/disapprove the applied service (s) to be provided.
Remarks…….
……
……..……
……..…
Name of the WCF official..…….……..……...
Designation……Signature….....……Date…….....
Official Stamp