KANSAS DEPARTMENT OF LABOR
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MEDICAL MANAGEMENT CLOSURE REPORT

K-WC-R 87-7 (11-16)

Date of closure: ______________________ Date of accident: ______________________

Vendor: ______________________ Vendor number: ____________

Claimant: ______________________ Social Security number: ______________

Street: ______________________

City: ______________________ State: ______ ZIP: ____________

Total cost for medical management services: $ ____________

Reason for Case Closure:

☐ 1. Claimant has returned to work.

Job title: ______________________

Employer: ______________________ Phone: (   ) ______________

Street: ______________________

City: ______________________ State: ______ ZIP: ____________

Date returned to work (mm/dd/yyyy): ____________ Current average weekly wage (AWW): $ ____________

AWW at date of accident: $ ____________

Complete below if job modified or accomodations made.

Modification/change made by employer to accommodate the physical limitation imposed by the injury/occupational disease:

Documentation of claimant's abilities to perform selected vocational objective:

I agree to return to work for employer with changes stated in this report.

Claimant's signature: ______________________ Date: ____________

It is my professional opinion that the position described in this plan is within the medical restrictions of this claimant.

Medical manager's signature (REQUIRED): ______________________ Date: ____________

Reason for Case Closure (cont'd

☐ 2. Claimant released to return to same job, same employer (without restriction); did not return to work.

☐ 3. Claimant released to return to same job, same employer (with restrictions); did not return to work.

☐ 4. Insurance company requested closure. Explain below:

☐ 5. Referred for vocational assessment.

☐ 6. Other (explain):

Medical manager's signature (REQUIRED): ________________________________ Date: ________________

Copy of closure report is required to be sent to claimant and attorney, if there is one.

cc: