



Verification of Employment for a Reported Workers' Compensation Injury or Illness

Please take this form to the doctor for your first medical examination.

Employee Name _____ Date of Injury _____

Date of Birth _____ Social Security _____

Reported Work Related Injury or Illness:

Ector County Independent School District's workers' compensation coverage provider is the Texas Association of School Boards Risk Management Fund which is a member of the Political Subdivision Workers' Compensation Alliance (the Alliance). For emergencies, an injured employee may go to the nearest emergency room. Otherwise, all other treatment must be from an Alliance Provider listed at pswca.org

Please submit all claims and medical billing information to:

TASB
P O Box 2983
Clinton, IA 52733-2983
Phone: 800.732.0153
Fax: 732.212.7009

eBill Information
Clearinghouse: WorkComp EDI
Clearinghouse website: www.workcompedi.com
TASB's Payer ID: WR902

Pre-Authorization
Phone: 800.482.7276 x 9907
Fax: 888.777.8272

Issuing Signature _____ Title _____

Phone Number _____ Date _____

Providers please submit Work Status Reports and all Job Description inquiries to:

Contact: Estela Vejil email: estela.vejil@ectorcountyisd.org

Phone: 432.456.9782 Fax: 432.456.9788

For a full list of Alliance Providers please visit pswca.org