QUICK REFERENCE GUIDE

HM WORKERS' COMPENSATION

Occupational Injury/Disease Report
Access eServices on **hmig.com** by clicking on the Workers' Compensation tab at the top of the page.

Assistance with Follow-up Appointments
Call: 877.444.4644

Pharmacy
Call: 877.444.4644

Medical Authorization Form
Fax: 800.749.9826

Workers' Compensation Earnings Report
Fax: 800.749.9826

Provider Bills
Fax: 800.749.9826

Other Questions/Concerns
Consult the HM Workers' Compensation Service Team

HM WORKERS' COMPENSATION SERVICE TEAM

Account Manager
- eServices
  - Claim Entry
  - Reports
- Physician Panels
- NPS Cards
- Account Review Meetings
- Ad Hoc Reports
- Liaison with Broker
- Return-to-Work Issues/Training

Loss Control
- OSHA Issues
- Health & Safety Questions/Concerns
- Safety Committees
- Specialized Safety Training

Claims
- Claim Updates
- RTW/Wage Loss/Modified Duty
- Reserves
- Provider Bills
- Medical Treatment
  - Prescription Drugs
  - Physical Therapy
  - Diagnostic Testing, etc.

HM Workers' Compensation
P.O. Box 2738 • Pittsburgh, PA 15230
800.880.7963 • hmig.com

HM WORKERS' COMPENSATION
AN HM INSURANCE GROUP PRODUCT

MTG-2513 (3/13)

HM INSURANCE GROUP
A HIGHMARK COMPANY
HM WORKERS' COMPENSATION

P.O. Box 2738
Pittsburgh, PA 15230
Phone: 800-880-7963
Fax: 800-749-9826
www.HMWorkersComp.com

WORKERS' COMPENSATION OCCUPATIONAL INJURY/DISEASE REPORT

Company Name _____
Location _____
Department _____
Policy Number _____

Print in blue or black ink.

EMPLOYEE INFORMATION

Last Name	First Name		☐ Male ☐ Female
Home Address	City	State	ZIP Code
Home Telephone Number	Work Telephone Number	Date of Birth	
Social Security No.	Marital Status ☐ Single ☐ Married ☐ Other	Hire Date	Job Classification
Job Title	☐ Full-time ☐ Part-time ☐ Salaried ☐ Hourly	Start time	Jurisdiction State
Work Address	City	State	ZIP Code

ACCIDENT DETAILS (Attach additional pages if necessary)

Date	Time ☐ AM ☐ PM	Date employee reported accident
Place of accident		
Loss Type ☐ Incident Only ☐ Medical Only ☐ Modified Duty ☐ Off Work		If off work, what was the first date
If the employee did miss work, has he/she returned to work? ☐ Yes ☐ No		If yes, date he/she returned to work
Type of Injury	Cause of Injury	
Body Part	☐ Left ☐ Right ☐ Unspecified	
Nature of injury (describe how the injury occurred)		

MEDICAL INFORMATION

Treating Physician

Last Name	First Name		Telephone Number
Address	City	State	ZIP Code

Family Physician				
Last Name	First Name			Telephone Number
Address	City		State	ZIP Code

External Medical Facility			
Organization Name			Telephone Number
Address	City	State	ZIP Code

WITNESS(ES) TO ACCIDENT (Attach additional pages if necessary)			
Last Name	First Name		
Address	City	State	ZIP Code
Home Telephone Number	Work Telephone Number	Job Title	
Last Name	First Name		
Address	City	State	ZIP Code
Home Telephone Number	Work Telephone Number	Job Title	

REPORT SUBMITTED BY	
Name	Date
Job Title	Work Telephone

INFORMATION RECEIVED BY		
Signature	Date	Time

FRAUD NOTICE

In New Jersey, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

In Pennsylvania, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

HM INSURANCE GROUP
A HIGHMARK COMPANY

HM WORKERS' COMPENSATION

P.O. Box 2738
Pittsburgh, PA 15230
Phone: 800-880-7963
Fax: 800-749-9826
www.HMWorkersComp.com

WORKERS' COMPENSATION AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(1) I hereby authorize any and all health care providers and/or insurance companies to release/disclose the following information of:
(Name of Releaser – e.g., HM Life Insurance Company, HM Life Insurance Company of New York, or other entity)

Patient/Member Name	Date of Birth
Address	
Identification Number	Telephone

The records to be disclosed cover the following period(s):

From Date of Birth (Date) to Present (Date)

From Not Applicable (Date) to Not Applicable (Date)

(2) ☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must ***not*** use it as an authorization for any other type of protected health information.

(3) Information to be disclosed

Designated Records:

☒ Enrollment Information ☒ Claims Information ☒ Payment Information

☒ Managed Care Information (Precertification, 2nd Opinions, Treatment Plans, Care Coordination, Case Management, etc.)

AND/OR

☒ Pharmaceutical information ☒ Discharge summary ☒ History and physical examination

☒ Consultation reports ☒ Progress notes ☒ Laboratory tests

☒ X-ray reports ☒ Explanation of Benefits ☒ Complete health record(s)

☒ Other (please specify) Emergency Room and Urgent Care Records, PT/OT/ST Progress Notes, Diagnostic Test Results

I understand that this will include information relating to (check if applicable):

☐ Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)

☐ Mental health care ☐ Sexually transmitted disease

☐ Treatment for alcohol and/or drug abuse ☐ Other (please specify) _____

(4) This information is to be disclosed to HM Insurance Group Member Companies or its representatives
(organization or provider)

by Releaser for the purpose of workers' compensation claim adjudication
(state purpose)

(5) I understand that I may revoke this authorization at any time by giving written notice of my revocation to HM Insurance Group Member Companies or its representatives. I understand that revocation of this authorization will *not* affect any action Releaser took in reliance on this authorization before it received my written notice of revocation. I also understand that without my written authorization, Releaser may not use or disclose my health information for any reason except those described in Releaser's Notice of Privacy Policies and Practices. Unless otherwise revoked, this authorization will expire on the following date, event or circumstance:
(insert date, event, or circumstance – if no date, event or circumstance is included, this Authorization will expire one year after date of member signature)

This Authorization is valid until the payment of the final invoice on the workers' compensation claim.

I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this authorization.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described above are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that Releaser may condition my enrollment or eligibility for benefits on my signing of this authorization (other than for psychotherapy notes), before Releaser enrolls me, to allow Releaser to obtain protected health information from another covered entity to determine my eligibility or enrollment or Releaser's underwriting or risk rating.

I understand that Releaser may condition payment of a claim for specified benefits on my signing of this authorization (other than for psychotherapy notes) to allow other covered entities to disclose protected health information to Releaser that Releaser needs to determine payment of my claim.

Releaser, its subsidiaries, affiliates, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed (Patient/Member) Date

(Personal Representative) (Include a description of such representative's authority to act for the patient/member) Date

You are entitled to a copy of this authorization after you sign it.

HM INSURANCE GROUP
A HIGHMARK COMPANY
HM WORKERS' COMPENSATION

P.O. Box 2738
Pittsburgh, PA 15230
Phone: 800-880-7963
Fax: 800-749-9826
www.HMWorkersComp.com

WORKERS' COMPENSATION MEDICAL TREATMENT WAIVER FORM

I decline to seek medical treatment for an incident that I reported as having occurred during the course and scope of my employment on _____.

My employer has provided me with their Workers' Compensation panel provider list from which injured employees must seek treatment for work related injuries requiring medical attention for a period of 90 days from the date of first visit.

I agree to notify my employer immediately should I choose to seek medical attention at a later date.

Employee Name: _____
Print Name

Employee Signature: _____ Date:_____
Signature

Employer: _____
Print

Witness Name: _____
Print Full Name

Witness Signature: _____ Date:_____
Signature