HMSA

Blue Cross Blue Shield of Hawai'i

An Independent Licensee of the Blue Cross and Blue Shield Association

WORKERS' COMPENSATION QUESTIONNAIRE

Patient Name: _____ HMSA Number: _____

Phone Number: Home: _____ Work: _____

Date of Injury/Illness: _____

Please describe how accident happened: _____

_____

Diagnosis or brief description of Injury/Illness: _____

_____

Have you filed for workers' compensation? Yes _____ No _____

If no, please explain why: _____

_____

Employer Name and Telephone Number: _____

( ) I am still seeking medical attention as a result of my work injury, and workers' compensation is paying expenses.

( ) I am no longer seeking medical attention as a result of my work injury, and my workers' compensation case was closed on _____. (Please send us a copy of the WC3-Carriers case report) (Date)

( ) My case has been denied and ( ) I will ( ) I will not be pursuing my claim. (If denied, please send a copy of explanation of denial)

( ) My case has been denied based on an Independent Medical Evaluation (IME) . Please send a copy of the IME.

( ) A decision was rendered on _____. (Please send a copy of the decision) (Date)

( ) My case in on appeal.

( ) There was a cash settlement on _____. (Please send a copy of the settlement agreement) (Date)

( ) My attorney's name: _____ Telephone Number: _____

Completed By: _____ _____
(Signature) (Date)

Also, please complete the Injury/Illness Report Form, and attach the completed form to this questionnaire when mailing.

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