WORKERS' COMPENSATION COMMISSION

CLAIM AMENDMENT

Instructions: This form must be completed in its entirety and be signed by the claimant.

Claimant's Name: _____
First Middle Last

_____ _____
WCC Claim Number **Date**

Claimant's Address: _____

City _____ State _____ ZIP Code _____

Employer/Insurer: _____

On _____ (Date) I, _____ (Claimant's Name),
filed a claim for compensation for an injury or occupational disease to the following body members (Form C-1, Box 33):

I wish to amend my claim for compensation to add the following body member(s):

I wish to amend my claim for compensation to remove the following body member(s):

I hereby amend my claim for compensation and certify that the foregoing facts are true and accurate.

_____ _____
Claimant's Signature **Date**

Certificate of Service

I hereby certify that on this _____ day of _____ , 2_____ , I mailed, postage prepaid, a copy of the foregoing "Claim Amendment" and "Authorization for Disclosure of Health Information" to all parties.

_____ _____
Signature **Date**

10 East Baltimore Street · Baltimore, Maryland 21202-1641
410-864-5100 · Email: info@wcc.state.md.us · Web: http://www.wcc.state.md.us

Clear This Page Print This Form

CLAIM AMENDMENT AUTHORIZATION
FOR DISCLOSURE OF HEALTH INFORMATION

Pursuant to Labor and Employment Article, §§ 9-709, Annotated Code of Maryland, and COMAR 14.09.01.06, this authorization must be signed and filed with the Workers' Compensation Commission of Maryland in conjunction with any claim amendment form.

A. **Person Covered by Authorization**

This document authorizes the disclosure of protected health information regarding:

Name/Claimant _____ Date of Birth _____

WCC Claim Number _____

B. Purpose of Disclosure

This document authorizes the disclosure of protected health information for the purpose of processing, adjudicating and resolving workers' compensation claims.

C. **Entities Authorized to Make Disclosure**

This document authorizes any health plan, physician, health care professional, dentist, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf to disclose my protected health information consistent with this directive.

D. Entities Authorized to Receive Protected Health Information

This document authorizes the disclosure of my protected health information to the following entities and their agents: my attorney, my employer, and my employer's workers' compensation insurer.

E. **Information to be Disclosed**

This document authorizes the entities listed in C to disclose protected health information that is relevant to the member of the body that was injured as indicated on the claim amendment form.

The protected health information that may be disclosed includes, but is not limited to: history, findings, office and patient charts, files, examination and progress notes, and physical evidence.

F. I understand that I may revoke this authorization by giving written notice to all parties to my claim for workers' compensation, except to the extent that this authorization has already been acted on prior to receipt of my revocation.

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient to a medical manager, health care professional or registered rehabilitation practitioner, and others consistent with state and federal law.

By signing this form, I am authorizing the disclosure of my protected health information. This authorization is valid for one year from the date the claim amendment is filed.

Patient/Claimant Signature _____ Date _____

A photocopy, facsimile or electronic transmission of this signed authorization form is valid.

WORKERS' COMPENSATION COMMISSION

CLAIM AMENDMENT

IMPORTANT: It is the Claimant's responsibility to maintain a current mailing address with the Commission. The Commission Claim Number should be included on all correspondence.

Disclosure Pursuant to COMAR 01.01.1983.18

1. The personal information requested on this form is intended to be used in processing your claim under the Maryland workers' compensation laws.
2. Failure to provide the information requested may result in your claim being rejected or a delay in the processing of your claim.
3. You may have a right to inspect, amend and correct the information provided on this form pursuant to State Government Article, §10-624, Maryland Code Annotated.
4. This form will be made part of your claim file. Portions of your claim file may be subject to public inspection.
5. The information contained on this form is routinely shared with State, Federal or local agencies.

Claim Filing Instructions

The Claim Amendment form must be used in order to amend a claim and add or delete a body part. This form may be downloaded from the Commission's website at the web address below. The Commission does not accept any claim forms, documents or claim-related information via facsimile (FAX) or email.

1. All entries MUST be hand written or typed. If hand written, print as clearly as possible in DARK OR BLACK INK.

2. Please provide all requested information in each space.

3. Dates should be filled in MM/DD/YYYY (month-day-year) format. "Leading zeros" must be entered with single digit numbers, for example, January 5, 1999 must be entered as 01/05/1999.

4. When information is not available, zeros MUST be entered. For example, Social Security Number: 000000000 (9 zeros.

5. Entries MUST NOT exceed the length of the indicated field. If the information is longer than the field allows, please abbreviate WITHOUT punctuation.

6. IF THERE IS NOT ENOUGH SPACE ON THE CLAIM FORM, PLEASE ATTACH ADDITIONAL PAGES WITH A PAPER CLIP. PLEASE NUMBER THE ITEMS THAT ARE BEING ADDED.

7. Please DO NOT cross out, staple, tape or use correction fluid or tape (White-Out) on the form.

8. A Claim Amendment form that does not contain the claimant's name, claim number, date of filing of original claim, the original member(s) of the body injured, the member(s) of the body that are to be added or removed, or sufficient information to process the claim may be rejected and returned to the claimant.

9. **Sign and date the Claim Amendment form.**

10. **Read, sign and date the Claim Amendment Authorization for Disclosure of Health Information.**

11. **A CLAIM AMENDMENT FORM THAT DOES NOT INCLUDE A SIGNED AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION WILL BE REJECTED AND RETURNED TO THE CLAIMANT.**

FAILURE TO FOLLOW THESE INSTRUCTIONS MAY RESULT IN THE REJECTION OF THE CLAIM AMENDMENT FORM.