FORM # 134

Complaint # _____

The Commonwealth of Massachusetts

Department of Industrial Accidents

Lafayette City Center, 2 Avenue de Lafayette
Boston, Massachusetts 02111

HEALTH CARE PROVIDER COMPLAINT FORM

Massachusetts General Law, Chapter152§13(3), requires the Health Care Services Board to receive and investigate complaints from employees, employers and insurers regarding health care providers who provide services in workers' compensation claims, where the providers are alleged to have engaged in patterns of:

- **(i)** discrimination against compensation claimants; ☐
- **(ii)** over-utilization of procedures; ☐
- **(iii)** unnecessary surgery or other procedures; or ☐
- **(iv)** other inappropriate treatment of compensation recipients ☐

Where the Health Care Services Board finds a pattern of abuse, it shall refer its findings to the appropriate Board of Registration. Please check (✓) the appropriate box above to indicate the category to which this complaint relates.

TO FILE A COMPLAINT, PLEASE PROVIDE THE FOLLOWING INFORMATION:

ABOUT *THE PERSON FILING* THIS FORM:

YOUR NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE:(_____)_____ TODAY'S DATE: _____

YOUR RELATIONSHIP TO THE COMPLAINANT:

_____

YOUR FIRM, COMPANY OR EMPLOYER:

_____

ABOUT THE HEALTH CARE *PROVIDER:*

PROVIDER'S NAME : _____

SPECIALTY (if known): _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: (_____) _____ THE DATE(S) OF THIS INCIDENT: _____

Using the following space, **summarize your complaint** about this health care provider **in 50 words or less**. *In addition*, attach a detailed narrative of your complaint to this form describing the treatment(s), procedure(s), date(s), location(s), and other facts relevant to the complaint.

_____

_____

_____

_____

Was this an *impartial examination* ordered by the Department of Industrial Accidents? YES ☐ NO ☐

Was this a health care service performed by the *employee's* treating health care provider, YES ☐ NO ☐

or

a service performed by a provider chosen by an insurer or employer? YES ☐ NO ☐

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT THE *COMPLAINANT*:

THIS COMPLAINT IS BEING FILED ON BEHALF OF AN (Please Check One): EMPLOYEE... ☐ EMPLOYER .. ☐ INSURER.. ☐ OTHER .... ☐

THE COMPLAINANT'S NAME: _____

COMPLAINANT'S COMPANY: _____

COMPLAINANT'S ADDRESS: _____ _____

CITY: _____ STATE: _____ ZIP CODE: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:

The following authorization for the release of medical information must be signed by the injured employee. If this complaint is filed by an insurer or employer referencing several injured employees to demonstrate a questionable pattern of care or service by a single provider, a signed authorization for release of medical information from each employee whose treatment is detailed in the complaint must be attached hereto.

EMPLOYEE'S AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize you to furnish the Department of Industrial Accidents' Health Care Services Board with all medical information, including but not limited to, medical records, test results, reports, and/or office notes, regarding an illness or injury for which you treated me during the period of _____ to _____.

I further authorize you to discuss with the Health Care Services Board any aspects of my illness or injury, or the treatment, diagnosis, or prognosis of my illness of injury.

A photocopy of this authorization should be regarded as a valid release of the information requested.

_____ _____
Date Signature of Employee/Patient

_____ - _____ - _____ _____
Social Security No. (optional) Name of Employee/Patient (please print)

_____ _____
Date of Birth Address

_____ _____ _____
City/Town State Zip Code

SEND THE COMPLETED COMPLAINT FORM, WITH ATTACHMENT(S), AND SIGNED EMPLOYEE AUTHORIZATION(S) TO:

DEPARTMENT OF INDUSTRIAL ACCIDENTS
HEALTH CARE SERVICES BOARD
LAFAYETTE CITY CENTER
2 AVENUE DE LAFAYETTE
BOSTON, MA 02111-1750

A COPY OF THIS COMPLAINT AND ALL ATTACHMENTS WILL BE FORWARDED TO THE PROVIDER.