



HEALTH CARE PROVIDER COMPLAINT FORM

Massachusetts General Law, Chapter 152, §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, 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: (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 or 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
600 WASHINGTON STREET, 7th FLOOR
BOSTON, MA 02111**

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