STATEMENT OF CLAIMANT

Name Street Address City State Zip Code	Home Telephone Number: Area Code Number ( )

Date of Birth	Social Security Number	Height	Weight	Right or Left Handed?

Name and Address of Employer

University of Mississippi, Department of Human Resources, P.O. Box 1848, 1111 Jackson Avenue Center - Central, University, MS 38677

Wages Per Hour ☐ Per Month ☐ $ Per Week ☐ Per Day ☐	Hours Worked Per Day: Days Worked Per Week:	Regular Occupation	How Long Have You Worked For This Employer?

Date of Accident	Hour AM or PM	Place of Accident

Describe Exactly How The Accident Occurred (use back of sheet if necessary)

What Part of Your Body Was Injured? Describe Your Injury In As Much Detail As Possible.

Name of Your Immediate Supervisor	To Whom Did You First Report Your Injury? When?

Names, Addresses and Phone Numbers Of Any Witnesses

Name and Address of Your Doctor (#1) Who Selected or Chose This Doctor?	Name and Address of Your Doctor (#2) (Use back of sheet to list other doctors if necessary) Who Selected or Chose This Doctor?

Date of First Doctor Visit?	When Did You Last See The Doctor?	Are You Still Seeing The Doctor?	If Yes, When Is Your Next Visit?

What Date Did You Start Losing Time From Work?	Have You Returned To Work?	If Yes, Please Give Date	If No, When Do You Expect To Return to Work?

Have You Ever Hurt or Had Problems With This Part of Your Body Before? If Yes, Please Advise When, Where, and Other Details.

Have You Ever Filed A Workers= Compensation Claim Before? If Yes, Please Advise When, Where, and Other Details.

Are you currently a Medicare or Social Security Disability recipient?

Signed (Signature of Claimant)	Date

Medicare Eligibility

1. Are you currently a Medicare Beneficiary?

   Yes☐ NO☐

2. Have you ever applied for Medicare and been denied benefits?

   Yes☐ No☐

3. Have you ever appealed a denial of benefits to Medicare?

   Yes☐ Date of Appeal: _____

4. Are you on Social Security Disability?

   Yes☐ No☐

5. If you are a Medicare Beneficiary, do you have a Medicare Advantage Plan?

   Yes☐ No☐

6. Please provide a copy of your Medicare Advantage Plan card or complete the information below:

   Name of Beneficiary: _____
   Medicare Claim Number/HICN # _____
   Member ID #: _____
   Effective Date: _____

Please sign below to signify that the above information is correct.

_____
SIGNATURE

_____
DATE

P.O. Box 1380
Ridgeland, MS 39158-1380
(601) 853-4949
(800) 264-8085
Fax: (601) 853-2727

Authorization for Release of Health Information

Name:	**Social Security #:**
Address:	
Employer Name: University of Mississippi	**AmFed Claim #:**

Personal Health Information to Be Disclosed:
My complete medical file, including but not limited to: doctors' and nurses' notes, x-ray reports and films, lab reports, history and physicals, admission and discharge summaries, physical therapy notes/reports, consultation and operative reports, admission sheets, blood alcohol test results, drug screening test results, histories and profiles, psychiatric records, prescription records, computer data or compilations or reports, itemized bills, psychotherapy notes, physician assistants' notes, diagnostic test results, ambulance reports, patient questionnaires, and all other forms of documents pertaining to each and every admission, emergency room, treatment, and clinic visit of the undersigned.

Purpose of the Disclosure: To investigate and determine workers' compensation benefits, and to perform treatment, payment and health care operations.

Right to Revoke: I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. To revoke authorization, I will contact AmFed Companies, LLC at the address above.

Signature: I _____, have had full opportunity to read and consider the contents of the authorization, and I confirm that the contents are consistent with my direction. I understand this authorization is voluntary. I understand that I am entitled to receive a copy of this authorization after I sign it. I understand that the information disclosed may be subject to redisclosure by the recipient and no longer protected. I hereby give my permission to disclose my personal health information in the manner described herein to my employer, **AmFed Companies, LLC**, their agents, employees, or attorneys. I hereby agree that a copy of this authorization form shall have the same force and effect as the original thereof and further agree that this authorization shall remain valid so long as my claim against my above named employer is pending.

Signature: _____ Date: _____

Witness: _____

If a personal representative on behalf of the individual signs this authorization, complete the following:
Personal Representative's Name: _____
Relationship to Individual: _____

NOTICE OF PHYSICIAN CHOICE

Employee's Name: _____

Employer's Name: University of Mississippi

Injury Date: _____

I am claiming to have sustained an injury involving my _____. (part of body)

I am ☐ am not ☐ claiming that my medical condition is work related. (check one)

If work related:

I understand that under the Mississippi Workers' Compensation Law I have the right to choose one (1) physician to render treatment to me. I can either accept the physician to whom I am sent by employer or choose someone else on my own.

I also understand that any referral to any other doctor must be made by my one chosen physician.

I also understand that my employer (or workers' compensation carrier) must approve any physician change and that if I change doctors without their authorization, I will be responsible for the medical expenses for the unauthorized treatment.

With that understanding, I state as follows:

☐ I accept as my choice of physician my employer's tender of treatment by Dr.

_____.

☐ I elect to choose my own physician to render treatment, and that choice is Dr.

_____.

_____
Employee's Signature:

_____
Date

Witnessed By: _____

_____