HealthComp

Patient:		**Claim No:**	
Employee:		**Provider:**	
Group No:		**Incurred:**	
Acct No:		**Charge**	

COVID-19 QUESTIONNAIRE

1. Was the patient identified above diagnosed with COVID-19?

   ☐ Yes
   ☐ No

   If the answer to Question 1 is "No", please skip all of the remaining questions, sign and date this form where indicated and return it with a copy of this letter to HealthComp.

2. Please specify the date the patient was tested, and the date the results were received.

3. What was the last date the patient worked, other than at home?

4. Has the patient filed a claim for workers' compensation related to their COVID-19 diagnosis?

   ☐ Yes
   ☐ No

5. If the patient filed a claim for COVID-19, what is the name and address of the patient's employer?

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6. Please provide a general description of the patient's job responsibilities with their employer, e.g providing health care services, general office work, retail, sales, etc.

7. If the patient filed a claim for workers' compensation, please provide the following:

   Insurance Company Name: _____
   Address: _____
   Phone: _____
   Policy #: _____
   Claim #: _____
   Policyholder's Name: _____

8. Has the patient hired an attorney to represent them regarding this condition?

   ☐ Yes
   ☐ No

   If "Yes", please provide the following:

   Attorney's Name: _____
   Address: _____
   Phone: _____

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HealthComp

We want to inform you that in the event your diagnosis is subject to State workers' compensation law, your Plan may be required to coordinate benefits with the workers' compensation carrier. This will not affect your ability to obtain benefits for your illness, and State and Federal law prohibit your employer from discriminating or retaliating against you as a result of your illness or the filing of a workers' compensation claim.

In the event the Plan has paid claims which are subject to workers' compensation, the Plan may have a right to obtain reimbursement from the workers' compensation carrier for any benefits paid. It is therefore important that you or your attorney remain in contact with us so the reimbursement amounts can be considered and that is does not affect the settlement of your claims.

I verify that the above information is true and correct to the best of my knowledge, and I have read and understood the Plan's right to be reimbursed for all benefits paid for the treatment of injuries related to this accident.

Signed: _____

Employee's Signature: _____

Date Signed: _____

Please complete this form and return it to **HealthComp:**

Mailing Address:
HealthComp
P.O. Box 45018
Fresno, CA 93718-5018

Fax:
(559) 499-2464

Questions? Please contact **HealthComp Customer Service** at (800) 442-7247, option 1.