TRAVELERS

TRAVELERS PROP CAS CO OF AMERIC
P.O. Box 660456
Dallas, TX 75266-0456

Gustavo Gonzalez
3460 Garden Avenue
Indianapolis IN 46222

CLAIM INFORMATION CARD

Name: Gustavo Gonzalez
Injury Date: 03/22/2024
Claim Number: F2T9279
Claim Professional: Jeneice Taylor
Claim Professional's Email: JPTAYLOR@travelers.com
Fax Number: (877)786-5567
Office Address: P.O. Box 660456,
Dallas, TX 75266-0456

TRAVELERS

We want to help you understand the claim process and what to expect so you can focus on what matters most - getting better.

REGISTER FOR MYTRAVELERS® FOR INJURED EMPLOYEES:
We invite you to register for MyTravelers® For Injured Employees, a single digital access point for all the resources you will need to take an active role in your recovery.

Simply visit https://signin.travelers.com to register. This intuitive, user-friendly platform is accessible from any device – computer, smartphone, or tablet.

Registering for MyTravelers® will enable you to:

- Set up electronic payments (Zelle® or PayPal®) to receive funds faster (availability varies by state)
- Upload documents directly to your claim and view documents we send you electronically
- Communicate easily with your Claim team by secure messaging
- View your detailed payment information
- Search for medical providers and pharmacies in your area
- Receive answers to frequently asked questions

I have included below reference to a form you need to complete and return to me along with the next steps. I have also provided additional information for your reference

FORM TO BE COMPLETED IMMEDIATELY
Please return the following form to me as soon as possible via secure email, mail or fax.

- **Authorization for Release of Medical Records:** This form will allow us to obtain medical information from your healthcare providers whose treatment may be relevant to your workers compensation claim.

NEXT STEPS
It is important that you attend all your medical appointments and that you get the treatment that you need as recommended by your doctor. We need the information below

to help determine any benefits you may be owed.

- Please make sure your doctor sends us the medical records after each of your appointments.
- To avoid a delay in benefits, please provide me a copy of your work status form from your doctor after every appointment.
- Please contact me after each appointment to let me know how you are doing.

Please also remember to stay in touch with your employer to provide regular updates regarding your progress and any work restrictions your doctor has indicated. **Please contact me immediately if you are receiving wages from your employer while receiving workers compensation lost time benefits.**

To protect your information, we recommend that you send all correspondence via secure email, mail or fax.

MEDICAL CARE

In Indiana, your employer has the right to choose the provider who will treat you for this injury. I will work with you and your employer to assist in the selection of an appropriate provider.

MEDICAL BILLS, MEDICATIONS, AND DURABLE MEDICAL EQUIPMENT

Please have your provider's office submit bills directly to Travelers at the office address on your Claim I.D. Card. If your provider prescribes a medication, please bring your I.D. Card to your local pharmacy and let them know you have a workers compensation claim with Travelers. If your provider prescribes durable medical equipment (DME), such as a cane or crutches, he/she can contact the DME provider via the phone number on the Claim I.D. card below.

DISABILITY BENEFITS - COMPENSATION FOR TIME LOST FROM WORK

Disability benefits are compensation for a portion of your lost wages. If your medical provider says you are unable to work due to your injury or your employer cannot provide you with transitional duty within the restrictions given to you by your medical provider, you may be eligible for benefits. In Indiana, you must be out of work for more than seven calendar days to be eligible for lost wage benefits. The seven-day waiting period will be paid if you are off of work for 22 days or longer.

It will be important for you to respond quickly to requests for information, so please check frequently for follow-up emails and mail from Travelers.

Please email me if you have additional questions using the information provided on your Claim I.D. Card.

CLAIM I.D. CARD

Name: Gustavo Gonzalez
Injury Date: 03/22/2024
Claim Number: F2T9279
Claim Professional: Jeneice Taylor
Claim Professional's Email: JPTAYLOR@travelers.com
Fax Number: (877)786-5567
Office Address: P.O. Box 660456,
Dallas, TX 75266-0456

For Pharmacy Use Only

Member I.D.: F2T9279TRV
Pharmacy Benefit Manager BIN #: 012874
Pharmacy Benefit Management Phone Number: 1-877-528-9497

For Medical Treatment Referrals Only

Diagnostic Referrals: One Call Care Management at 1-866-360-3242
or Orchid Medical at 1-855-429-2339.
Durable Medical Equipment (DME): One Call Care Management at 1-866-360-3242
or Homelink at 1-866-834-5360.
Physical Therapy: SPNet Clinical Solutions at 1-888-654-0049
or MedRisk at 1-800-225-9675.

TRAVELERS

TO CURRENT PROVIDER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS BY A HOSPITAL/PROVIDER FOR THE PURPOSE OF ADJUSTING A WORKERS COMPENSATION CLAIM FOR BENEFITS

Patient Name: Gustavo Gonzalez
Date of Birth: 07/21/1991
Claim Number: 028-CB-F2T9279-P
Date of Injury/Illness: 03/22/2024

I, the undersigned, authorize:

_____
(HOSPITAL/PROVIDER)

to release my medical records, reports and other protected health information ("PHI") to:

Travelers Prop Cas Co Of Americ
(PERSON OR ENTITY TO WHOM INFORMATION IS TO BE DISCLOSED)

and its attorneys and/or representatives. The PHI to be disclosed is relevant medical records and reports, and prescribed medications, relating to my medical treatment/consultation/examination and/or diagnostic procedures performed by the above-named provider, or at the medical facility, which pertains to my above referenced injury/illness for which I am claiming workers compensation benefits. This release does not authorize the release of information relating to any treatment for a psychological/psychiatric condition, alcohol and drug abuse or HIV/AIDS status.

I understand that I have the right to refuse to sign this authorization.

I understand that I have the right to receive a copy of this authorization and inspect and copy any PHI disclosed pursuant to this authorization.

I understand that I have the right to revoke this authorization. In order to revoke this authorization I may, at any time, send written notification to the above-named hospital/provider. I understand that my revocation of this authorization is ineffective to the extent that the above-named hospital/provider has relied on this authorization to disclose PHI relating to me.

I understand that PHI disclosed pursuant to this authorization may be redisclosed by the person or entity I have identified above and may no longer be protected from disclosure to others by federal or state law. I understand that the above-named hospital/provider may not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to determine a date or event at which time this authorization expires. unless previously revoked by me, this authorization expires one year from the date signed.

I further understand that federal HIPAA law does not require me to provide an authorization in this form as the purpose of this authorization relates to a workers compensation matter. However, I understand that as a practical matter, my authorization in this form may facilitate the processing and administration of my claim for workers compensation claim for benefits.

A copy of this authorization shall have the same force and effect as an original.

My signature below indicates that I have read and understand this Authorization and its terms.

_____ 04/03/2024
Signature of Patient Date

_____ _____
Signature of Parent, Guardian or Legal Representative, if applicable Date

_____ _____
Witness, if Authorization is signed by someone other than the Patient Date

TO PRIOR PROVIDER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS BY A HOSPITAL/PROVIDER FOR THE PURPOSE OF ADJUSTING A WORKERS COMPENSATION CLAIM FOR BENEFITS

Patient Name: Gustavo Gonzalez
Date of Birth: 07/21/1991
Claim Number: 028-CB-F2T9279-P
Date of Injury/Illness: 03/22/2024

I, the undersigned, authorize: _____
(HOSPITAL/PROVIDER)

or any health plan, physician, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided treatment to me to release/disclose, in writing, protected health information ("PHI") to:

Travelers Prop Cas Co Of Americ
(PERSON OR ENTITY TO WHOM INFORMATION IS TO BE DISCLOSED)

and its attorneys and/or representatives. The PHI to be disclosed includes medical records and reports, and prescribed medications, relating to my medical treatment/consultation/examination and/or diagnostic procedures performed for prior care and/or treatment which may be relevant in the adjustment of above referenced injury/illness for which I am claiming workers compensation benefits. This release does not authorize the release of information relating to any treatment for a psychological/psychiatric condition, alcohol and drug abuse or HIV/AIDS status.

I understand that I have the right to refuse to sign this authorization.

I understand that I have the right to receive a copy of this authorization and inspect and copy any PHI disclosed pursuant to this authorization.

I understand that I have the right to revoke this authorization. In order to revoke this authorization I may, at any time, send written notification to the above-named hospital/provider or, if unnamed, to the person or entity to whom the information was disclosed. I understand that my revocation of this authorization is ineffective to the extent that any hospital/provider has relied on this authorization to disclose PHI relating to me.

I understand that PHI disclosed pursuant to this authorization may be redisclosed by the person or entity I have identified above and may no longer be protected from disclosure to others by federal or state law. I understand that the above-named hospital/provider may not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to determine a date or event at which time this authorization expires. unless previously revoked by me, this authorization expires one year from the date signed.

I further understand that federal HIPAA law does not require me to provide an authorization in this form as the purpose of this authorization relates to a workers compensation matter. However, I understand that as a practical matter, my authorization in this form may facilitate the processing and administration of my claim for workers compensation claim for benefits.

A copy of this authorization shall have the same force and effect as an original.

My signature below indicates that I have read and understand this authorization and its terms.

Signature of Patient	Date 04/03/2024
Signature of Parent, Guardian or Legal Representative, if applicable	Date
Witness, if Authorization is signed by someone other than the Patient	Date