FHM Insurance Company
WECARxE®
WORKERS' COMPENSATION

GRIEVANCE PROCEDURE

IF YOU ARE INJURED ON THE JOB

Your employer and Workers' Compensation carrier are concerned that you receive appropriate medical treatment.

Your employer has a list of health care providers and can assist you in selecting a provider from within the Rockport Network. If you need to be referred to another provider or need emergency care, you may choose from the list of providers participating in the Network.

If you are dissatisfied or have questions concerning the medical care and treatment provided by a **WECARxE** provider, you may, within one year from the date of treatment or care in question, file a complaint by contacting the Grievance Coordinator or your Nurse Case-Manager at 888-346-3461, ext. 323.

The Grievance Coordinator and/or Nurse Case-Manager will coordinate a resolution to the complaint and contact a Physician Advisor if necessary. The Physician Advisor may require medical examinations and/or other information from you and the Network provider depending on the nature of the dispute. If the Physician Advisor is unable to resolve the dispute to your satisfaction within ten (10) days, the matter will automatically be referred to the Medical Director.

The Medical Director will issue a decision within thirty (30) days unless further information is required, in which case an additional thirty (30) days will be allowed. If an agreement is not reached and you are not satisfied with the decision of the Medical Director, you may file a request for grievance reconsideration with the Division of Workers' Compensation.

If you have any questions concerning the Rockport Network, call 888-346-3461, ext. 323 or write:

Rockport Healthcare Group
50 Briar Hollow Lane
Suite 515 West
Houston, TX 77027

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888.346.3461
www.fhmic.com

Florida Workers' Compensation Managed Care Arrangement
FORMAL GRIEVANCE FORM

An Injured Worker or Health Care Provider shall use this form to request a formal review about dissatisfaction with medical care issues provided by or on behalf of a Workers' Compensation Managed Care Arrangement.

This Grievance is Filed by: ___Provider ___Injured Worker or a Designated Representative: ___Family Member ___Attorney ___Other
Date of Injury _______________

INJURED WORKER'S/PROVIDER'S NAME: ______________________________
Social Security Number ______________________________
Address: ______________________________
Home Telephone: ______________________ Work/Alternate Phone: ______________________
Contact if other than injured worker or provider ______________________ Telephone # ______________

PRIMARY CARE/TREATING PHYSICIAN: ______________________________
Address: ______________________________
Office Telephone: ______________________________

If the space provided below is inadequate for you to fully explain your concern or the action you desire, continue your statement on a sheet of plain paper. Please be sure your name and social security number appear on each page of any attachment.

Why is this grievance being filed? (Nature of the problem): ______________________________

____
____
____
____
____
____

Has a grievance been previously filed? ____YES ___NO IF YES, Date sent? ______________________

What Action Would You Like to See Taken? ______________________________

____
____
____
____
____
____

Have you received any information regarding your rights and responsibilities under WC Managed Care? Yes___ No___

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INTENT: The grievance procedure is intended to be self-executing and easy to use. An injured worker may call the grievance coordinator directly without completing this form. The grievance coordinator may complete the form for the injured worker. A review regarding the requested medical care will begin immediately, and a decision made within 44 days of receipt unless additional information is required from outside the service area. The review period may be extended by mutual agreement between the injured worker and the grievance coordinator, with notice provided to all other participating parties.

The injured worker's participation in the grievance process is important to the resolution of medical issues. Individuals reviewing the grievances may need to speak directly with and receive input from the injured worker. If the injured worker is unable to participate actively in the grievance process, a patient advocate may participate on behalf of the injured worker.

If the injured worker, employer, or carrier is dissatisfied with the final decision of the grievance committee, the dissatisfied party has the right to file a Petition for Benefits with the Florida Division of Workers' Compensation.

Any person who, knowingly and with intent to injure, defraud, or deceive any employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Form Completed by: ______________________________ ________________________
Injured Worker/Provider/Other Date Form Completed/Signed

____ ________________________
Signature of Grievance Coordinator Date Grievance Coordinator Signed

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MAIL TO:

Grievance Coordinator
AmeriSys
PO Box 616648
Orlando, FL 32861-6648
407 351 1212, ext. 417