



**Allstate**  
You're in good hands.

Piedmont MCO  
PO BOX 320237  
CHARLOTTE NC 28232

November 22, 2010

INSURED:  
DATE OF LOSS:  
CLAIM NUMBER

PHONE NUMBER: 800-366-8995  
FAX NUMBER: 866-858-0879  
OFFICE HOURS: Mon - Fri 8:00 am - 4:45 pm,  
Sat 8:00 am - 2:00 pm

Dear

Thank you for taking the time to discuss your injury claim with me. As we discussed, in order to evaluate your injury claim, I will need to obtain your medical bills and reports and verify any wage loss you might have. I have enclosed an authorization for your signature which will allow me to contact your medical providers and employers for this information.

This authorization is an important document. You should read it carefully before you decide to sign it. If you should have any questions concerning this matter, do not hesitate to call me. Please complete the form and return it to me in the enclosed self-addressed envelope.

Should you wish to discuss any aspect of this case including this letter, please call me at the number below, and refer to our claim number.

Sincerely,

800-366-8995  
Allstate Indemnity Company

Enclosure(s)



## MEDICAL PROVIDER/EMPLOYER INFORMATION

To assist us in processing your claim, please complete this form and return it to Allstate Indemnity Company with the medical and/or wage authorization. We will need to request copies of your medical records and itemized bills in order to properly evaluate your injury claim. Providing the proper names and addresses of all providers who have treated as a result of this claim will help in expediting the handling of the claim. If more space is needed than the form allows please continue on the backside. If you need to add any medical providers in the future, please contact your claim representative. **Please return promptly.**

Claim:  
Insured:  
Claimant:  
Date of Loss:  
Our Fax Number:

*(REMAINDER OF FORM IS FILLED OUT BY RECIPIENT)*

### Providers:

Hospital or Emergency Care Center: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone #: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

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Treating Physician (or Primary Care Physician):  
\_\_\_\_\_

Name of Clinic Practicing at: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone #: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

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Other Treating Provider: \_\_\_\_\_

Name of Facility: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone #: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_



Claim No. \_\_\_\_\_

DATE \_\_\_\_\_

### HIPAA COMPLIANT AUTHORIZATION

List below the names and addresses of all persons (Doctors, Dentists, Hospitals, Nurses, Funeral Directors, etc.) who rendered, or who are rendering services in connection with injuries sustained in this accident and the amount of bills, if known.

NAME AND ADDRESS

AMOUNT OF BILL

<u>NAME AND ADDRESS</u>	<u>AMOUNT OF BILL</u>

To Whom It May Concern:

For purposes of evaluating a claim made by me, or on my behalf, and/or for preparing for, conducting, and/or participating in any mediation, arbitration, hearing, trial, or other proceeding associated with my claim, you are hereby authorized to furnish to Government Employees Insurance Company, GEICO General Insurance Company, GEICO Indemnity Company, GEICO Casualty Company, or any of its representatives (individually and collectively referred to as "GEICO") any and all medical information which may be requested concerning my physical and/or mental condition and treatment (excluding "psychotherapy notes" as defined in 45 CFR 164.501) to include, diagnosis, prognosis, and any and all records, files, or other documentation concerning the treatment, prescription, consultation or other advisory visits or events (collectively referred to as the "Records") that pertain to:

- \_\_\_\_\_  
**[PATIENT: PRINT YOUR NAME ABOVE]**
- DOB: \_\_\_\_\_  
**[PATIENT: WRITE YOUR BIRTH DATE ABOVE]**
- SSN: \_\_\_\_\_  
**[PATIENT: WRITE YOUR SOCIAL SECURITY NUMBER ABOVE]**
- The Records covered by this HIPAA Compliant Authorization cover the time period beginning five (5) years prior to the date of last treatment through **[PATIENT: INDICATE YOUR LAST DATE OF TREATMENT IN THE FOLLOWING SPACE]** \_\_\_\_\_, 20\_\_\_\_, the date of last treatment, and up to and including the date of Provider's compliance with this HIPAA Compliant Authorization.
- The Records shall specifically include, but shall not be limited to, such condition and treatment as may pertain to the automobile accident/loss/claim of **[PATIENT: INDICATE THE DATE OF THE AUTOMOBILE ACCIDENT/LOSS/CLAIM IN THE FOLLOWING SPACE]** \_\_\_\_\_, 20\_\_\_\_\_.

The information covered by this HIPAA Compliant Authorization includes, but is not limited to, reports, records, test results, X-rays, and any other diagnostic testing, whether in your possession or available to you. I understand that the information in the Records may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, behavioral health care/psychiatric care (excluding "psychotherapy notes" as defined in 45 CFR 164.501), and treatment for alcohol and/or drug abuse, and/or substance abuse. Copies of this Authorization shall be considered as valid as the original. This information is being requested for the purpose of evaluating a

**GOVERNMENT EMPLOYEES INSURANCE COMPANIES  
ATTENDING PHYSICIAN'S REPORT**

Date	Our Policyholder	Date of Accident	Claim No.
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To assist us in determining what may be due the Applicant, the Attending Physician should complete this report and return it directly to:

GOVERNMENT EMPLOYEES INSURANCE COMPANIES  
CLAIMS DEPARTMENT  
ONE GEICO CENTER  
MACON, GA 31296

1. Patient's Name and Address:			
2. Age:	3. Sex:	4. Occupation:	
5. History of occurrence, as described by Patient:			
6. Diagnosis and Concurrent Conditions:			
7. Date symptoms first appeared:		8. Date when Patient first consulted you for this condition:	
9. Has Patient ever had same or similar condition? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, state when and describe:			
10. Is condition solely a result of this accident? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, explain:			
11. Is condition due to injury or sickness arising out of Patient's employment? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, explain:			
12. Will injury result in permanent disfigurement or disability? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, describe:			
13. Was Patient hospitalized as a result of this injury? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, where:			
14. Was Patient unable to work? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, FROM: THROUGH:		15. If still disabled, date Patient should be able to return to work:	
16. Report of Services:			
Date of Service	Place of Service	Description of Surgical or Medical Service	Charges
			\$
			\$
			\$
<b>TOTAL CHARGES TO DATE</b>			<b>\$</b>
17. Is this Patient still under your care for this condition? <input type="checkbox"/> YES <input type="checkbox"/> NO		Estimated Future Charges: \$	
18. Is any part of your bill covered by MEDICARE or MEDICAID? <input type="checkbox"/> YES <input type="checkbox"/> NO			

Date	Physician's Name (print)	Physician's Signature	IRS/TIN Identification No.
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Number	Street	City or Town	State	Zip Code
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