

Health Care Provider Report

See instruction on the next page
 (Return completed form to requester)
 Enter dates in MM/DD/YYYY format



H C 0 1

DO NOT USE THIS SPACE

WID number or SSN	Date of injury	Date of birth
Employee	Employer	
Insurer/self-insurer/TPA	Insurer claim number	
Insurer address		
City	State	ZIP code

Requester must specify all items to be completed by health care provider: Items _____ MMI (#9) PPD (#10)

Health care provider to complete items requested above.

1. Date of first examination for this injury by this office: _____

2. Diagnosis (include all ICD-10-CM codes):

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3. History of injury or disease given by employee:

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4. In your opinion (as substantiated by the history and physical examination) was the injury or disease caused, aggravated or accelerated by the employee's alleged employment activity or environment? No Yes

5. Is there evidence of pre-existing or other conditions that affect this disability? No Yes If yes, describe:

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6. Is further treatment of this injury or referral to another health care provider planned? No Yes If yes, describe:

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7. Has surgery been performed? No Yes If yes, date of surgery: _____ If yes, describe:

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8. Are there physical restrictions? No Yes If yes, describe:

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Attach the most recent report of work ability. Date of report: _____

9. **Has the employee reached maximum medical improvement (MMI)?** No Yes Date reached: _____
 (If yes, complete item 10.) (See definition under instructions to the health care provider.)

10. **Has the employee sustained any permanent partial disability (PPD) from the injury?** No Yes Too early to determine
 The permanent partial disability is _____ % of the whole body. This rating is based on Minnesota Rules:

5223.	%
5223.	%

5223.	%
5223.	%

Health care provider name	Signature	Degree
Address	License/registration number	State
City State ZIP code	Phone (include area code)	Date signed

Notice to employee: Service of this report of maximum medical improvement (see definition below) may affect your temporary total disability wage-loss benefits. If the insurer proposes to stop your benefits, they must send you a notice of intention to discontinue benefits. If you have any questions about this form, call your claim representative or call the Department of Labor and Industry at (651) 284-5032 or 1-800-342-5354.

Instructions to the requester and health care provider

The employer, insurer or commissioner may request required medical information on the Health Care Provider Report form.

- The requester must complete the general information identifying the employee, employer and insurer.
- The requester must specify all items to be answered by the health care provider.
- The requester must send a copy of this form to the employee at the same time it is sent to the health care provider.
- If an injury is required to be reported to the Department of Labor and Industry, the self-insured employer or insurer must file reports with the department (Minnesota Statutes § 176.231, subd. 1, and Minnesota Rules 5221.0410, subps. 5 and 8).
- The self-insured employer or insurer must serve the report of maximum medical improvement (MMI) on the employee (Minn. Stat. § 176.101, subd. 1(j), and Minn. Rules 5221.0410, subp. 3).

The health care provider must provide the requested information on this form or in a narrative report within 10 calendar days of the receipt of a request (Minn. Rules 5221.0410, subps. 3, 4 and 6).

- Item 6: Indicate if further treatment or referral is planned. Describe the treatment plan, for example: continue medication, refer to physical therapy, refer to a specialist, perform surgery.
- Item 7: Indicate if surgery has been performed. If yes, fill in the date performed and describe the procedure.
- Item 8: Attach the most recent Report of Work Ability form or a narrative report that contains the same information.
- Item 9: Indicate if the employee has reached MMI. If yes, fill in the date MMI was reached. At MMI, permanent partial disability (PPD) must be reported (see item 10).

Maximum medical improvement means: "The date after which no further significant recovery from or significant lasting improvement to a personal injury can reasonably be anticipated, based upon reasonable medical probability, irrespective and regardless of subjective complaints of pain" (Minn. Stat. § 176.011, subd. 13a).

- Item 10: The health care provider must provide an opinion of PPD when ascertainable, but no later than the date of MMI.

Indicate if the employee sustained PPD from this injury. Check one of the three boxes (no, yes, too early to determine). For dates of injury Jan. 1, 1984, through June 30, 1993, use Minnesota Rules 5223.0010 through 5223.0250. For dates of injuries July 1, 1993, and later, use rules 5223.0300 through 5223.0650. Report the complete rule number for all ratings, even if the rating listed is zero. Refer to the specific ratings in Minn. Rules chapter 5223, to determine whether to "add" or "combine" the ratings. If you have questions about how to assign a rating under the PPD rules, contact the Department of Labor and Industry at (651) 284-5032 or 1-800-342-5354.

- Identify the health care provider completing the report by name, professional degree, license or registration number, address and phone number.
- The health care provider must sign and date the report.

This document can be given to you in Braille, large print or audio. To request, call (651) 284-5032 or 1-800-342-5354.

Any person who, with intent to defraud, receives workers' compensation benefits to which the person is not entitled by knowingly misrepresenting, misstating or failing to disclose any material fact is guilty of theft and shall be sentenced pursuant to Minn. Stat. § 609.52, subd.3.