APPENDIX D

HealthSmart Identification and Verification

Date

Claimant
Address
City State Zip

Dear Claimant:

You are fortunate that your employer has chosen to work with HealthSmart. We understand that a work-related injury or illness can be very unsettling. We also realize that your focus and attention is directed on your recovery and returning to your job. You can turn to HealthSmart for assistance in eliminating any confusion that you may have in your care.

When you receive medical care in a hospital, clinic, or through any medical provider, you must identify yourself as a HealthSmart participant. To assist you, we have provided the identification card below. Detach this card and present it to the provider when you register.

Please obtain from your employer the HealthSmart list of providers and HealthSmart Employee Manual. If you have any questions about your participation in HealthSmart call 1-866-659-9315.

HealthSmart SMARTER HEALTHCARE SOLUTIONS **Identification And Verification** **To Health Care Providers**: • This patient is employed by a company that is a member of HealthSmart, a West Virginia Workers' Compensation provider network. • Except for emergency care, the patient must be treated by a HealthSmart provider. You may obtain a provider listing by calling **1-866-659-9315** • Opt-out provisions may apply • Communicate promptly **This verification card is not to be construed as authorization for medical services or payment.**	Employer: _____ Address: _____ Phone: _____ _____ **Managed Care Plan** Address all HealthSmart correspondence or inquiry to: **HealthSmart** **222 W. Las Colinas Blvd. #500N** **Irving, TX 75039** **Phone: 1-866-659-9315** **For billing correspondence or claims inquiry to:** **Zurich American Insurance** PO Box 66941 Chicago, IL 60666-0941 1-800-257-8134
Employee Instructions: • Report your injury to your employer. • Select a provider from the HealthSmart provider listing and make an appointment. • Provide this card to any health care provider from whom you are seeking treatment for a work-related condition. • Keep your employer informed of any medical treatment you receive.	**Employee Identification** Employee Name: _____ Employee SSN: _____ DOI: _____