(EMPLOYER LETTERHEAD)

Date

Dear Employee:

AIG, the administrator of your employers’ workers’ compensation benefits; your employer; and the Coventry Network are pleased to provide you with the Massachusetts Preferred Provider Arrangement (PPA). Please note our enrollment is effective \_\_\_(input date)\_\_\_\_\_\_\_\_. The MA PPA is designed to provide quality medical services for work-related injuries or illnesses. This letter is intended to serve as an overview of your rights and responsibilities:

1. Should you have a work related injury or illness you need to report all injuries immediately or as soon as possible. You are required to obtain treatment within the Preferred Provider Arrangement for the first scheduled appointment or you may be responsible to pay for such appointment. Exceptions to treating with a provider within the PPA are:

A. You may seek Health Care Services for a work related injury/illness outside the Preferred Provider Arrangement for the initial scheduled appointment without any financial obligation when such appointment is with a licensed or registered Health Care Provider of a type or specialty not represented within the Preferred Provider Arrangement. Diagnosis, excessive travel time, or the presence of any pre-existing medical condition which would make treatment substantially more difficult may be additional causes for the need to treat outside the network.

B. If you need emergency medical treatment, seek the care that you need and inform your employer immediately. Emergency treatment means those medical services required for the immediate diagnosis or treatment of a medical condition that if not immediately diagnosed or treated could lead to serious physical or mental disability or death, or medical services that are immediately necessary to alleviate severe pain.

2. After the initial scheduled appointment, you may seek Health Care Services for a work related injury/illness outside the Preferred Provider Arrangement without responsibility to pay for these visit(s);

3. Please be aware that no co-payments or deductibles may be charged for those with work related injuries/illnesses who utilize the Preferred Provider Arrangement or any other Health Care Provider;

4. Should you find the medical services rendered to be unsatisfactory you have the right to file a complaint with the Health Care Services Board within the Division of Industrial Accidents. AIG encourages effective communication between all parties involved in the Preferred Provider Arrangement and will take appropriate, prompt corrective action, when necessary, to address your valid concerns and issues. Additional information on this process is attached for your review, including a Grievance Form.

5. To locate a Coventry Network physician please visit our website at [www.aig.com/intellirisk](http://www.aig.com/intellirisk) and choose “find medical care.” Under the radius search choose “first treatment providers” and click “refine further.” We recommend an Occupational/Industrial Medicine provider due to their focus and expertise with industrial injuries. This provider shall be considered your Gatekeeper. A nurse practitioner shall also be considered a qualified provider. You may also locate a first treatment provider by reviewing your worksite poster or by contacting your employer.

6. Utilization Review and Telephonic Case Management Services are performed by Health Direct Inc. (HDi). Any time during the course of treatment, if your physician recommends any services that require utilization review, (s) he must contact HDi before the services are performed, by telephoning: (877) 479-3829 and fax 877-479-3830.

Thank you for your participation in the Massachusetts Preferred Provider Arrangement.

**Grievance Process**

If you are dissatisfied with the handling of a medical issue, a network medical provider, or have any other problem, which cannot be resolved by speaking with the parties involved, you may submit a grievance:

You can initiate this process by telephone, mail, or e-mail, with the preferred method being the completion of the attached Grievance Form. When completing this form, describe the nature of your complaint and the action you request. Any supporting documentation should be attached. The Grievance Form should be sent to the Grievance Coordinator at AIG listed above.

AIG will provide a written acknowledgment of receipt of a grievance within 15 business days of receipt and a written resolution of a grievance within 30 business days. The 30 business day time period for written resolution of a grievance without the review of medical records, begins on the day the grievance is received. Should the grievance require the review of medical records, the 30 day timeframe will not begin until all medical records have been received.

Prior to issuing a response, AIG may request additional information or may need to speak with you or your treating physician. All outcomes will be made in compliance with accepted medical practice guidelines and with your best medical interests. Your participation is important to a timely resolution.

If you do not get a sufficient response, you may contact the consumer assistance toll-free number of the Office of Patient Protection at 800-436-7757.

**Grievance Form**

An injured worker may use this form to submit a concern regarding a specific medical issue, network medical provider, or any other problem, which cannot be resolved by direct discussion with the appropriate parties.

**THIS FORM IS FILED BY:**

Injured Worker’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care/Treating Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Physician Office Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Describe the nature of the issue or concern:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What action would you desire?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has a concern been previously filed for this issue? 􀂆 Yes 􀂆 No

If yes, date filed: \_\_\_\_\_\_\_\_\_\_\_

Form completed by:

*Injured Worker’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Date \_\_\_\_\_\_\_\_\_\_\_

*Employer/Insured Signature*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

Mail/e-mail to:

AIG, 99 High Street, Boston, MA 02110

Attn: Sue Spicuzza, Pre-Injury Consultant/Grievance Coordinator

Phone 617-794-4436 or 800-448-9707; [Susan.spicuzza@aig.com](mailto:Susan.spicuzza@aig.com)