North Dakota Workforce Safety & Insurance

HERNIA QUESTIONNAIRE

CLAIMS DIVISION
SFN 52960 (12/2020)

1600 E Century Ave, Ste 1
PO Box 5585
Bismarck ND 58506-5585
Telephone 800-777-5033
Toll Free Fax 888-786-8695
TTY (hearing impaired) 800-366-6888
Fraud and Safety Hotline 800-243-3331
www.workforcesafety.com

SECTION 1 – *Employee's information*

Claim number	Employee's (First name)	(Last name)
Body part(s)		

SECTION 2 – *Current hernia(s)*

When did you first notice the symptoms of the present condition and what specifically were your symptoms?

What were you doing at the time when you first noticed the symptoms?

Did you stop working immediately due to the pain? ☐ Yes ☐ No	If yes, for how long?
Did you mention the incident to anyone at the time it occurred? ☐ Yes ☐ No	If yes, who?
Did you have a protrusion or swelling? ☐ Yes ☐ No	If yes, when did you first notice the protrusion or swelling?

Was your doctor able to reduce the protrusion or swelling? ☐ Yes ☐ No

Did the symptoms continue or progress? ☐ Yes ☐ No

If yes, explain.

Do you have a family history of hernia's? ☐ Yes ☐ No	Do you currently smoke or have a history of smoking? ☐ Yes ☐ No

SECTION 3 – *Prior hernia(s)*

Have you had a hernia before (example: umbilical, inguinal, incisional)? ☐ Yes ☐ No

Which area is affected (example: left groin)?

Was it surgically repaired? ☐ Yes ☐ No	Have you had any treatment for the prior hernia since it was treated or repaired? ☐ Yes ☐ No

If yes, list the date(s), name(s), and addresses of all medical providers who treated your prior hernia(s).

Have you had any prior abdominal or groin surgeries? ☐ Yes ☐ No

If yes, list the date(s), name(s), and addresses of all medical providers who treated you for the prior surgery.

C149

Claim number	Employee's (First name)	(Last name)

Have you had any prior imaging such as CT scan, MRI, or ultrasound of the abdomen?
☐ Yes ☐ No

If yes, list the date(s), name(s), and addresses of all medical providers where imaging was performed.

SECTION 4 – *Release of information/fraud warning/signature*

Release of information

I understand and agree that North Dakota law determines all my rights and obligations to and from WSI. I authorize any medical provider or facility, any insurance company, including workers' compensation relating to work injuries, any law enforcement or military agency, any government benefit agency including the Social Security Administration, and any educational agency or institution to release to WSI, its agents and attorneys, any and all information or records, including all prior records as well as those pertaining to mental health, alcohol, or drug abuse, and HIV/AIDS/AIDS-related illness. I authorize healthcare providers to respond to WSI regarding my injury, including request for conclusions and opinions not otherwise contained within existing medical records. In addition, I authorize any education agency or institution to release to WSI any and all "educational records" as defined by 20 U.S.S 21 Sec. 1232g.

This authorization lasts for 1 year after the date signed unless I enter a different expiration date here _____.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

WSI is exempt from HIPAA regulations. I authorize WSI to release any information or records about my claim to third parties or their insurers for the purpose of resolving claims against third parties. I authorize the release of any medical information related to my claim to my employer.

Fraud warning

Any person claiming benefits or compensation from WSI who files a false claim, or makes a false statement, or fails to notify WSI as to the receipt of income or an increase in income from employment, in connection with any claim or application for workers' compensation benefits will forfeit any future benefits and may be guilty of a felony which is punishable by imprisonment, substantial fines, or both. These criminal penalties are applicable to all persons dealing with WSI, including injured employees, employers, medical providers, and attorneys.

Signature

By signing this form, I acknowledge that I have read and understand the release of information and fraud warning. I understand that falsifying this claim or making a false statement regarding this claim may be a felony, punishable by substantial fines and imprisonment. I authorize the release of information and agree that statements in this form are true and accurate.

Employee's signature	**Date**