AIMS™
ACCLAMATION INSURANCE
MANAGEMENT SERVICES

September 15, 2011

Claim Number: VE090000198
Employer: San Joaquin Count MVCD
Date of Injury: 6/29/11

Tiffany Anderson
2 N. Avena Ave
Lodi, CA 95242

Dear Ms. Anderson:

As you know, AIMS is the Workers' Compensation Claims Administrator for San Joaquin County MVCD. The purpose of this letter is to address the status of your 6/29/11 claim for workers' compensation benefits.

Based on the medical, legal and factual evidence at hand, your claim for benefits is accepted.

The California Labor Code provides for the following worker's compensation benefits for accepted worker's compensation claims: medical treatment reasonably required to cure or relieve you from the effects of the injury, temporary and permanent disability indemnity payments for medically verified lost time or permanent impairment and a job retraining voucher if you are not able to return to work due to permanent impairment resulting from your injury.

You have previously been provided a "Mileage Reimbursement Request" for documenting and claiming reimbursement for travel to and from medical appointment related to this condition. You may also use it to request reimbursement for out of pocket expenses, if any.

If you have lost time because of the injury, please provide both the medical releases and an accounting of the time lost; please note that the first 3 days (24 hours) of lost time are not compensated unless you are off work for more than 14 days. At the present time it does not appear though there will be permanent impairment due to this injury but we await the final word from your treating physician, along with his recommendations for future medical care and will advise accordingly.

At present all medical treatment bills have been paid. There are certain statutes of limitations regarding your workers' compensation claim that are briefly discussed in the information previously provided; in the interim, please cal me if your have additional questions, comments or concerns regarding this or any of these benefits at (916)563-1900, ext. 242.

Supplemental Injury Questionnaire

**** Please fill out as completely as possible, using the other side or additional pages if necessary.**

1. Have you ever been injured before? Include all previous accidents, injuries, illnesses, athletic/motor vehicle, on or off the job. ☐ YES ☐ NO

   If yes, please indicate date, type of injury, and the name(s) of any doctors who treated you.
   Date ***Type of Injury*** ***Physician Name/Phone Number***

2. Have you filed other workers' compensation claims with this or any other employer? ☐ YES ☐ NO

   If yes, please indicate date/type of injury, employer and any settlements or awards you have received.
   Date ***Type of Injury*** ***Employer Name*** ***Settlement (Type and Amount)***

3. Please indicate if you have engaged or do engage in any of the following activities in the past 12 months:

   ☐ Tennis ☐ Football ☐ Basketball ☐ Baseball/Softball ☐ Jogging/Running ☐ Bicycling
   ☐ Swimming ☐ Soccer ☐ Golfing ☐ Home Computer ☐ Play Musical Instrument
   ☐ Knit/Crochet ☐ Gardening ☐ Bowling ☐ Motorcycling
   ☐ Video Games ☐ Exercise at gym/Lift weights ☐ Coaching ☐ Crafting ☐ Other:

4. Do you have other medical conditions (for example, diabetes, arthritis, blood pressure, thyroid, pregnancy, etc)? ☐ YES ☐ NO

   If yes, please list the condition(s), physician(s), and ALL medications currently being prescribed/taken:
   Medical Condition ***Physician Name/Phone Number*** ***Medication(s)***

5. Do you have another job (paid, home business or volunteer) with this or another employer, other than the one where you injured yourself? ☐ YES ☐ NO

   If yes, please indicate where you work, your occupation/years at job, and describe your general job duties.
   Employer Name ***Occupation/Years at job*** ***Job Duties***

By signing below I acknowledge that I have completed the information to the best of my ability and have not intentionally omitted any requested information.

Signed: _____ Date: _____

Tiffany Anderson

Acclamation Insurance Management Services, Inc.
PO Box 269120 • Sacramento, CA 95628
Phone: (916) 563-1900 • Fax: (916) 563-1919 • www.aims4claims.com

NAME: Tiffany Anderson Date _____

Employer:	Claim No:	Date of Injury:
San Joaquin County MVCD	VE090000198	6/29/11

Under the California Worker's Compensation Law, You are entitled to reimbursement of reasonable mileage to and from medical appointments or treatment for your industrial injury or illness. Mileage will be reimbursed at the rate of .50 per mile

DATE	FROM	TO (DOCTOR'S NAME)	ROUND TRIP MILEAGE

If you desire additional forms, please check here_____ TOTAL MILES_____

Signature:_____

I further understand that I have a right to receive a copy of this authorization upon my request.

We ask that you list all medical providers you have seen in the past five years regardless of whether it was work related or not.

Please return the signed release within 14 days, failure to do so may result in denial of your claim.

Medical Provider Name Address/Phone # Year Seen Specialty

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Employee's Signature Date

_____ _____

Employee's Address Employee's Phone #

ACCLAMATION INSURANCE
MANAGEMENT SERVICES

Re: Employee: Tiffany Anderson
Employer: San Joaquin County MVCD
Claim No.: VE090000198
Date of Injury: 6/29/11

AUTHORIZATION TO RECEIVE OR RELEASE MEDICAL, EMPLOYMENT, SOCIAL SECURITY, SCHOLASTIC, AND INSURANCE RECORDS

I, **Tiffany Anderson**, hereby authorize all health/medical/insurance providers and/or employers, not limited to physicians and hospitals, to furnish any/all of my personnel/employment records, Social Security Administration records, scholastic records, insurance claim files and medical records, past and present, including for personal and industrial injuries to:

Acclamation Insurance Management Services
P.O. Box 269120
Sacramento, CA. 95826

The disclosure of records authorized herein is to be used by AIMS for purposes of review, investigation, evaluation and/or processing of a workers' compensation claim.

I further release my attending physician and his/her associates and the hospital and its employees and agents from liability from the release of this information or records to such designated person or agencies.

This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier, it shall remain valid for one year from the date signed.

This authorization is pursuant to California Evidence Code Section 1158, when applicable. A photocopy of this signed release may be used in lieu of an original.

I understand that the requester may not lawfully further disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Thank you and best wishes for a complete recovery.

Sincerely,

Mackenzie Dawson
Sr. Claims Examiner

Encl: Mileage Request

Cc: File