

UT HEALTH SCIENCE CENTER AT SAN ANTONIO

**BLOODBORNE PATHOGEN POST-EXPOSURE TREATMENT
MEDICAL RECORD RELEASE FOR UTHSCSA EMPLOYEES**

Employee must complete this form in order to apply for reimbursement or initiation of payment to a provider for post-exposure treatment not covered by Workers' Compensation Insurance.

Employee Name: _____
Last Name First Name

Social Security #: _____ - _____ - _____

Home Address: _____
City State Zip

Home Phone: _____ Work Phone: _____

1. During the normal course and scope of my duties as an employee at UTHSCSA the exposure incident happened on: _____
Mo Day Yr
2. I notified my supervisor : _____
Last Name First Name
On _____ (immediate supervisor must be notified immediately or as soon as possible following the incident).
Mo Day Yr
3. Yes: _____ I have received payments or reimbursements from another entity for this claim.
No: _____ I have not received payments or reimbursements from another entity for this claim.

The cost of wound care will be billed to the employer's Workers' Compensation Insurance. Other prophylactic treatment costs not covered by Workers' Compensation Insurance may be submitted for payment review to the Office of Human Resources Workers' Compensation Coordinator:

Office of Human Resources/WCI, MSC 7972
University of Texas Health Science Center
7703 Floyd Curl Drive
San Antonio, Texas 78229-3900
(210) 567-2595

By signing this form, I agree to release the applicable medical records & billing documentation necessary to complete the application process. These records will be reviewed by Human Resources, Institutional Safety, and Accounting, during the process.

Print Name: _____

Employee Signature: _____

Date: _____

WCI Resource Allocation Program
Blood-borne Pathogen Exposure

Request for Provider Payment or Employee Reimbursement

Employee Information

Employee Name: _____

SS #: _____ **Department:** _____

Date of Injury: **WCI Claim #:** _____

Type of Injury: _____

Payment Information

Total: _____

Type: Employee Reimbursement Payment to Provider

For: Testing Follow-up Testing Prophylactic Prescription Other

Pay to: (Name) _____

(Address) _____

Additional Information or Comments

Submitted by: Barbara Bates, Workers' Compensation Coordinator **Date:** _____

Department: Human Resources

Phone: (210) 567-2595 **FAX:** (210) 567-6790

DEPARTMENT MUST PROVIDE DISCLOSURE TO EMPLOYEE

The University of Texas Health Science Center at San Antonio

NOTICE FOR REQUEST OF DISCLOSURE OF SOCIAL SECURITY NUMBER (Worker's Compensation)

Disclosure of your Social Security Number ("SSN") is required of you in order for The University of Texas Health Science Center at San Antonio to report, process, or reimburse a Workers' Compensation claim, as mandated by State law, Texas Labor Code § 401-415, 402.087; 28 Texas Admin. Code § 41.15, 42.30, 102.8, 120.1, 120.4, 122.2, 122.5, 122.100, 131.3, 133.206, 133.302, 134.504, and the Texas Workforce Commission. Further disclosure of your SSN is governed by the Public Information Act (Chapter 552 of the Texas Government Code) and other applicable law.

NOTICE ABOUT INFORMATION LAWS AND PRACTICES

With few exceptions, you are entitled on your request to be informed about the information The University of Texas Health Science Center at San Antonio collects about you. Under Sections 552.021 and 552.023 of the *Texas Government Code*, you are entitled to receive and review the information. Under Section 559.004 of the *Texas Government Code*, you are entitled to have The University of Texas Health Science Center at San Antonio correct information about you that is held by The University of Texas Health Science Center at San Antonio and is incorrect, in accordance with the procedures set forth in The University of Texas System Business Procedures Memorandum 32. The information that The University of Texas Health Science Center at San Antonio collects will be retained and maintained as required by Texas records retention laws (Section 441.180 et seq. of the *Texas Government Code*) and rules. Different types of information are kept for different periods of time.

<p>You may send any requests to Harry S. Lynch Jr., MBA, CPA By mail to: 7703 Floyd Curl Drive, San Antonio, TX 78229-3900 By e-mail to: Lynch@UTHSCSA.edu By fax to: (210) 567-7027 In person at: Medical School Building, Room 426</p>
