



**HM
WORKERS'
COMPENSATION**

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**WORKERS' COMPENSATION
MEDICAL TREATMENT WAIVER FORM**

I decline to seek medical treatment for an incident that I reported as having occurred during the course and scope of my employment on _____.

My employer has provided me with their Workers' Compensation panel provider list from which injured employees must seek treatment for work related injuries requiring medical attention for a period of 90 days from the date of first visit.

I agree to notify my employer immediately should I choose to seek medical attention at a later date.

Employee Name:

Print Name

Employee Signature:

Signature

Date: _____

Employer:

Print

Witness Name:

Print Full Name

Witness Signature:

Signature

Date: _____

Coverage is underwritten by Highmark Casualty Insurance Company, Pittsburgh, PA, or HM Casualty Insurance Company, Pittsburgh, PA. Highmark Casualty Insurance Company may provide certain administrative and customer support services. The coverage or service requested may not be available in all states.