

# Termination of Medical Benefits

## Quick Start Guide

Filing the C-10 is easier than ever! Just use the integrated form in CompHub to file, and get your submission processed quicker.



▼ Claim Details

Claim Number: W301277

Claimant: Carlos Medina

▼ Employer & Insurer Details

Employer Name	Insurer Name
AMGEN INC	A M C O INSURANCE COMPANY

Review the top section of the form. It is pre-populated with basic Claim Information.

Enter the *Termination Date* manually or use the integrated date-picker. The form will only accept dates in the future. (The date will automatically default to the next day.)

This is to advise that the insurer/employer will terminate payment for medical benefits under the above captioned claim effective: 12/14/2022

▼ The claimant has the right to request a hearing before the Workers' Compensation Commission on the issue of this termination of medical benefits

Please enter the name of the healthcare provider for whom treatment or service is being terminated.

Please use the add icon (+) to include the Healthcare Information

To delete / edit a particular row, select the corresponding row and then click on the appropriate icon (delete / edit).

▼ Healthcare Information

Healthcare Provider	Service Terminated
<input type="text"/>	<input type="text"/>

Click the **Plus Sign** to add Healthcare Providers and services for which you are terminating.

▼ Upload documents

Please click + icon below to add new supporting document(s)

All attachments should be converted to PDF format before uploading

To delete / edit a particular row, select the corresponding row and then click on the appropriate icon (delete / edit).

▼ Attachments

<input type="text"/>
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No records

Attach any relevant documentation using the table in the "Upload Document" Section.

For further information, contact Insurer: ART HEBBELER Phone Number: 123-456-7890

▼ INSURER CERTIFICATION OF SERVICE

I HEREBY CERTIFY that on December 13, 2022, that service of the foregoing was made to all parties entitled to service in accordance with COMAR 14.09.01.03 and 14.09.06.04.

By checking this box, I affirm this is the electronic signature of the submitter for all purposes under the Maryland Workers' Compensation Law, Title 9 of the Labor & Employment Article of the Annotated Code of Maryland and the Maryland Uniform Electronic Transactions Act, Title 21 of the Commercial Law Article of the Annotated Code of Maryland.

Don't forget to Certify and Sign! Check the appropriate boxes on the left side.