Accident Reporting Procedures

- ☐ Assess the employee's injuries and ask initial questions to determine *if it is work related*.
- ☐ If medical treatment is necessary, send the claimant to your approved physician. If it is after the hours for the approved physician, utilize the local ER **only** in an emergency or if the employee can not wait until they open.
- ☐ Complete the entire **Employers First Report of Work Injury or Illness.** Make sure to complete using terminology such as "the employee states…" or the "employee claims…"
- ☐ Have the employee sign and completely fill out the **HIPAA Compliant Authorization for Release of Protected Health Information** and C-31 (Tennessee only)
- ☐ Send the **Physician Report of Employee Injury** with the employee to the medical provider.
- ☐ Fax or E-mail all completed information to **OccuSure within 24 hours**
- ☐ Please Report: **Record only** (no treatment) **Medical Only** (medical treatment, no days lost from work) and **Lost Time** claims.
- ☐ We will contact you after receiving the claim for further investigation as necessary.

Submit all MEDICAL BILLS to:

OccuSure
P.O. Box 682829
Franklin, TN 37068
Fax: 615 377-4735 or 877 622-7871

PRESCRIPTION PROCEDURES

We have a contract with major pharmacies such as Walgreens, Walmart etc. to ensure that you receive the best prices available. Should a pharmacy call you for approval, have them contact us or refer to our billing information listed on the PHYSICIAN'S Form.

SUBMIT CLAIMS TO OCCUSURE:

FAX: (615) 377-4735 OR 877-622-7871
E-Mail: janderson@occusure.com

AFTER HOURS EMERGENCY PHONE:
(615) 414-5569
If you need immediate assistance for a serious injury or death that occurs after normal business hours.

PO Box 682829
Franklin, TN 37068
Phone: 615-373-0500
Fax: 615-377-4735

Fax

To: Claims Adjustor,

From:

Fax: 615-377-4735 / 877-622-7871

Pages:

Phone: 615-373-0500

Date:

Re: Occupational Injury

Claim Type:

☐ **No Medical Treatment (Report Only)**

☐ **Med Only Claim**

Please make sure to complete the following when submitting the claim:

☐Employers First Report of Work Injury or Illness

☐Employees Choice of Physician Form (if required)

☐HIPAA Compliant Authorization for Release of Protected Health Information

☐Any Medical Notes received from medical provider and Work Status Form

Note: Please make sure forms are *completely filled out and legible* before faxing. Please

C20 EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS

The use of this form is required under the provisions of the Tennessee Workers' Compensation Law and must be completed and filed with your insurance carrier immediately after notice of injury.

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

If you have questions, the state now has a benefit review system where a Workers' Compensation Specialist can provide assistance. Call 1-800-332-2667 (TDD).

CLAIMS ADM/CARRIER

JURISDICTION CLAIM # (STATE FILE #)

CLAMS ADM CLAIM # (INSURER CLAIM #)

OSHA LOG CASE #

CLAIM TYPE CODE
MED ONLY
INDEMNITY
BECAME LOST TIME
BECAME MED ONLY
NOTIFY ONLY
TRANSFER

NAME OF INSURANCE CARRIER

CARRIER FEIN

CLAIMS ADMIN FIRM NAME (if different from carrier) **OccuSure**

FEIN OF CLMS ADM **20-524-8843**

CLAIMS ADJUSTER NAME

CLMS ADJ PHONE # **877-622-7870**

CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2 **1885 GENERAL GEORGE PATTON DRIVE**

CITY **FRANKLIN** | STATE **TN** | ZIP **37067**

EMPLOYER

EMPLOYER NAME

EMPLOYER FEIN

SIC CODE

PHONE NUMBER

EMPLOYER ADDRESS LINE 1 AND LINE 2

NATURE OF BUSINESS

CITY | STATE | ZIP

INSURED REPORT NUMBER

EMPLOYER LOCATION #

POLICY

INSURED NAME (parent co. if different than employer)

POLICY NUMBER

SELF INSURED? YES NO

EFF DATE

EXP DATE

EMPLOYMENT STATUS CODE
FULL TIME/REGULAR
PART TIME
PIECE WORKER
SEASONAL
VOLUNTEER
APPRENTICE FULL TIME
APPRENTICE PART TIME

EMPLOYEE

EMPLOYEE LAST NAME

PHONE INCL AREA CODE

FIRST | MI

DEPARTMENT REGULARLY WORKED

GENDER
MALE
FEMALE
UNKNOWN

ADRRESS LINE 1 & 2

OCCUPATION DESCRIPTION

CITY | STATE | ZIP

MARITAL STATUS
UNMARRIED, SINGLE, DIVORCED
MARRIED
SEPARATED
UNKNOWN

NCCI CLASS CODE

SSN | DATE OF BIRTH | DATE OF HIRE

WAGE

WAGE $

PERIOD
HOURLY
DAILY
WEEKLY
BI-WEEKLY
MONTHLY

NUMBER OF DAYS WORKED PER WEEK

SALARY CONTINUED IN LIEU OF COMPENSATION YES NO

FULL WAGES PAID FOR DATE OF INJURY YES NO

ACCIDENT / INJURY

DATE OF INJURY

TIME OF INJURY
COULD NOT BE DETERMINED
AM PM

TIME EMPLOYEE BEGAN WORK ON INJURY DATE
AM PM

DATE EMPLOYER NOTIFIED OF INJURY

BODY PART AFFECTED CODE

NATURE OF INJURY CODE

CAUSE OF INJURY CODE

DATE CLAIM ADM NOTIFIED OF INJURY

DATE LAST DAY WORKED

DATE DISABILITY BEGAN

RETURN TO WORK DATE (IF APPLICABLE)

How injury or illness occurred. Describe the incident including what the employee was doing just before, the part of the body affected and how, and object or substance that directly harmed the employee.

DATE OF DEATH (IF APPLICABLE)

IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP
WIDOW
WIDOWER
MOTHER
FATHER
____ DAUGHTER
____ SON
____ SISTER
____ BROTHER
____ HANDICAPPED CHILD
TOTAL # DEPENDENTS

DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? YES NO

ADDRESS WHERE INJURY OCCURRED (if other than employer's premises)

CITY | STATE | ZIP

COUNTY OF INJURY

TREATMENT

PHYSICIAN NAME

HOSPITAL OR OFF SITE TREATMENT NAME

ADDRESS LINE 1 AND 2

ADDRESS LINE 1 AND 2

CITY | STATE | ZIP

CITY | STATE | ZIP

INITIAL TREATMENT
NO MEDICAL TREATMENT
MINOR BY EMPLOYER
MINOR BY CLINIC/HOSPITAL
HOSPITALIZED > 24 HRS
EMERGENCY CARE
FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

OTHER

DATE PREPARED

PREPARER' NAME & TITLE

PREPARER'S COMPANY NAME

PHONE NUMBER

FORM C-31

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Division of Workers' Compensation

MEDICAL WAIVER AND CONSENT

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE DIVISION OF WORKERS' COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. § 50-6-204 AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

I, _____, having filed a claim for workers' compensation benefits, do hereby authorize

_____
(Name of Medical Provider)

to furnish to the employer (or the employer's representative, such as the insurance company) and/or the Division of Workers' Compensation any information reasonably related to my work-related injury. The authorization includes, but is not restricted to, a right to review and obtain copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.
This authorization shall remain valid for 180 days following its execution. A photocopy of the authorization may be accepted in lieu of the original.

Dated: _____, 20____.

_____ _____
Patient Social Security last four numbers

_____
Witness

Pursuant to the Rules of the Department of Labor and Workforce Development 0800-2-17-.15, any physician, psychiatrist, chiropractor, podiatrist, hospital or health care provider shall, within a reasonable time, not to exceed thirty (30) days, provide the requesting party with any information or written material reasonably related to the injury for which the employee claims compensation.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

***This medical authorization form complies in all respects with HIPAA.**

TO: _____

You are authorized and requested to give to _____ (hereinafter "Employer"); Johnston and Associates, DBA OccuSure Claims Services and the designated workers compensation insurance carrier (hereinafter "Insurer"); or their representative counsel; any information or opinion they may request regarding any physical condition and any treatment which has been rendered to me, including but not limited to diagnosis and prognosis, and allow the representatives and/or agents of Employer, Insurer, or their representative counsel to see and copy any and all records available, including but not limited to x-rays, regarding my condition and treatment and/or all of my hospital records and charts. I understand that the Employer, Insurer, or their representative counsel is requesting this information in connection with a workers' compensation matter in which I am involved. I also understand that Employer, Insurer, or their representative counsel will be responsible for the charges incurred in obtaining this information.

The Employee also expressly and unequivocally consents to allow the representatives and/or agents of Employer, Insurer, or their representative counsel; to have direct verbal or written contact and communication with all treating physicians, informally and without the employee present, regarding any and all confidential information related to the Employee's health disclosed or gained through the physician-patient relationship, regardless of the relation of said information to the alleged workers compensation claim. This authorization is valid for five (5) years from the date of execution.

I understand that I have the right to revoke this authorization in writing; however, in order to revoke this authorization I must give written notice of my intent to revoke this authorization to the Employer, Insurer, or representative counsel at least thirty (30) days prior to the date the revocation is to take effect. I also understand and agree that any information used or disclosed pursuant to this authorization may be subject to redisclosure by Employer, Insurer, or representative counsel and no longer protected by law.

I understand that I may inspect or copy the protected health information received by Employer, Insurer, or representative counsel procured exclusively as a result of this authorization by submitting a written request to Employer, Insurer, or representative counsel.

I further understand that I do not have to sign this authorization; however, I have freely signed this authorization. I also acknowledge that I have received a signed copy of this authorization. I have read, fully understand, and heretofore consent to all aspects of this authorization, as evidenced by my signature below.

A copy or facsimile of this document shall have the same validity and effect as the original.

EXECUTED this _____ day of _____, 20___.

EMPLOYEE/PATIENT

DATE OF BIRTH: SOCIAL SECURITY NUMBER

PHYSICIAN'S REPORT OF EMPLOYEE INJURY

TO BE SENT WITH INJURED EMPLOYEE AND GIVEN TO PHYSICIAN

All referrals for testing or to another doctor require authorization. All bills for authorized medical treatment must have corresponding medical notes attached and should be directed to:

OccuSure PO BOX 682829 / FRANKLIN, TN 37068 615-373-0500/ FAX 615-377-4735

TO BE COMPLETED *BY EMPLOYER* PRIOR TO TREATMENT BY PHYSICIAN:

Employer Name:

Address: **City:** **State:** **Zip:**

Phone:_____ **Fax:** _____ **Contact:** _____

Name of Injured Employee:_____ **Date of Injury:**_____

Description of Incident:_____

Body part(s) To Be Treated:_____

Authorized Employers Signature:_____ **Date:**_____

Employees Signature (for treatment on the above injury):_____ **Date:**_____

TO BE COMPLETED BY TREATING PHYSICIAN:

Date of First Treatment:_____

Initial Complaint: (*NOTE TO TREATING PHYSICIAN: Employee is to be treated for the injury listed above. Any other treatment that is not related must obtain prior authorization.)_____

Diagnosis:_____

Nature, extent, degree, body location of injury:_____

Treatment Prescribed and Prognosis:_____

Medications/Testing Prescribed:_____

X-Rays taken ☐ Yes ☐ No **If yes, results:** ☐ Positive ☐ Negative

Drug/Alcohol Screen is Required for Initial Visit
Completed
Yes No
Results should be sent to Employer

_____

Was there any evidence of a prior or pre-existing injury or illness ____yes ____no **If yes, what condition and to what extent may it contribute to incapacity or recovery?**_____

_____

To help employees return to work more quickly, a temporary modified/light duty program is available, this employee:

☐ May return to work today without restrictions ☐ May return to work today with restrictions as indicated below for _____days

☐ May not return to work until _____ Reason_____

If restrictions are required, please indicate below

- No standing over _____ hrs.
- No overhead reaching
- No use using _____hand/upper extremity
- No climbing
- No pushing/pulling over _____lbs.
- Keep wound clean, dry
- No lifting over _____ lbs
- No stooping/bending/twisting
- No walking over ____hours
- No weight bearing _____foot
- No operation of machines
- Other:_____

Released to restricted duty on _____,20_____ **Released to regular duty on**_____,20_____

Will employee require further medical treatment? ____No ____ Yes, PRN ____Yes **If yes, date of next appt:** _____

Expected date of MMI **Please explain**_____

Signature of Physician: **Date**: