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– Vision –

To be the company of choice for
associates, agents, and policyholders.

– Mission –

Exceed in service. Lead in results.

– Core Values –

Excellence

Integrity

Innovation

WORKERS' COMPENSATION REPORTING TIPS

– ATTENTION – YOU MAY BE FINED IF YOU DO NOT REPORT ON-THE-JOB INJURIES ON TIME

You must complete an Employer's First Report of Injury immediately after an on-the-job injury occurs and forward the report to Argent. **You may be fined if you do not submit the report on time.**

Report online, fax, or email the Employer's First Report of Injury even if you do not have all the information about the injury.

- Do not wait for medical bills.
- Do not withhold the Employer's First Report of Injury because you believe the claim is questionable. Reporting a loss is not an admission of liability.
- Be sure to include the claim number on all correspondence.

Claim Reporting Options for NEW LOSSES ONLY:

- Online Reporting (Insured Access) - Our online reporting system is referred to as Insured Access. **Online claim reporting is our preferred method**, and allows you to instantly obtain confirmation of your report, as well as the claim number. Insured Access also allows you to have limited access to claim notes, claim reserves, and loss control resources. In order to set up Insured Access, please contact your dedicated claim representative. Or,
- Fax: 888-926-9299 or,
- Email: ArgentWCCLossScanCtr@wbmi.com

Do not withhold the Employer's First Report of Injury for any reason. You may be fined if the claim representative cannot make the initial lost time payment because you failed to send the Employer's First Report of Injury on time.

If you need to notify your agent, please send your agent a copy of the Employer's First Report of Injury and indicate the report has been filed with Argent. Direct reporting saves time.

If you have any questions, please call your claim representative.

For any follow up correspondence, please refer to the below instructions:

Submit follow up correspondence with the claim number to:

- Fax: 888-926-9299
- Email: Argent_WCC_scan_ctr@wbmi.com

HOW TO WRITE INJURY DESCRIPTIONS

The following instructions will help you avoid some common errors and save time when describing an injury on the Employer's First Report of Injury form.

For most accidents, you can describe what happened in one or two sentences. "He strained his lower back lifting a box." "She bruised her left knee when she fell on a wet floor." However, your descriptions must be specific. "Hurt back working" does not provide enough information.

Answer the following questions when describing an injury:

1. What part of the body was injured?

- Lower back
- Right forearm
- Upper right leg
- Third toe on left foot

2. How did the accident happen?

- Did the person fall?
- Did they twist their body as they got out of a chair?
- Were they moving or stationary when the accident happened?

3. Was the injured person carrying anything?

Even if it probably didn't cause the injury, we need to know if the person was carrying anything. For example, "Carrying broom, stepped wrong and twisted left ankle."

4. What specifically appears to have caused the accident?

If someone hurt their back lifting a box, say that. Don't say:

- Lifting a unit of material
- They hurt their back lifting product
- Lifting equipment

Avoid jargon or trade names for equipment. Explain precisely what they were doing.

- Lifting an air conditioner
- Pushing a cart
- Carrying magazines
- Bending over to pick up a wrench

If a machine caused the injury, tell us what kind.

- A grinder
- A shear
- A hoist

Again, avoid jargon or trade names.

5. What injury appears to have resulted?

- Strain
- Fracture
- Bruise
- Cut

Please be sure to include the injured person's birthdate or age and Social Security number. Also, indicate the geographical location of the accident (city, county, and state).

Loc Code _____ Dept Code _____

Workers' Compensation – FIRST REPORT OF INJURY OR ILLNESS

Jurisdiction Code _____ Jurisdiction Claim Number _____

CLAIM ADMIN	Claim Administrator Name: Argent			Claim Representative Business Phone Number: 800-236-5008		Insurer Name (if different than claim administrator):	
	Mailing Address, City, State, & Postal Code: 1900 South 18th Avenue West Bend, WI 53095 Fax: 888-926-9299			Claim Administrator Claim Number:		Insurer FEIN:	
				Claim Administrator FEIN: 39-0698170		Claim Type Code:	
EMPLOYER	Employer Name:			Employer FEIN:		Insured Report Number:	Employer Type Code:
	Physical Address, City, State, & Postal Code:			Mailing Address, City, State, & Postal Code:		Industry Code:	<input type="checkbox"/> Employer (E) <input type="checkbox"/> Lessor (L)
	Nature of Business:			Employer Contact Name and Business Phone Number:		Insured Location Number:	Employer UI Number:
POLICY	Insured Name (parent co. if different than employer):	Insured FEIN:	Insured Postal Code:	Policy/Contract Number:	Coverage Effective Date:	Self Insurance License/ Certificate Number:	
					Coverage Expiration Date:		
EMPLOYEE	Employee Name (First, Middle, Last, & Suffix):		Date of Birth:	Gender:	Tax Filing Status (check one)		
	Mailing Address, City, State, & Postal Code:		Date of Hire:	<input type="checkbox"/> Male (M) <input type="checkbox"/> Female (F)	<input type="checkbox"/> Single (A) <input type="checkbox"/> Single/Head of Household (B)	<input type="checkbox"/> Married/Filing Joint (C) <input type="checkbox"/> Married/Filing Separate(D)	
				Educational Level (grade completed): _____ [GED = 12]		Marital Status: (check one)	
	Phone Number (include area code):		Employment Status (check one):		Employee ID Number (check one):		Employee's Authorization to Release the Following: Medical Records <input type="checkbox"/> yes <input type="checkbox"/> no Social Security Number <input type="checkbox"/> yes <input type="checkbox"/> no
	Occupation Description:		<input type="checkbox"/> Piece Worker <input type="checkbox"/> Volunteer <input type="checkbox"/> Seasonal <input type="checkbox"/> Apprenticeship/Full-Time <input type="checkbox"/> Apprenticeship/Part-Time <input type="checkbox"/> Regular Employee/Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Other		ID # _____ Social Security Number Employment VISA Number Passport Number Green Card Employee ID Assigned by Jurisdiction		
	Manual Classification Code:						
	Department Where Regularly Worked:						
WAGE	Average Wage \$ _____ (check one): <input type="checkbox"/> hourly <input type="checkbox"/> daily <input type="checkbox"/> semi-monthly <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> annual <input type="checkbox"/> weekly		Salary Continued In Lieu of Compensation: <input type="checkbox"/> yes <input type="checkbox"/> no		Employee Number of Dependents: _____		
	Number of Days Regularly Worked Per Week: _____		Full Wages Paid for Date of Injury: <input type="checkbox"/> yes <input type="checkbox"/> no		Employee No. of Exemptions: _____(check one) <input type="checkbox"/> Entitled <input type="checkbox"/> Withholding		
			Discontinued Fringe Benefits: \$ _____				
ACCIDENT/INJURY	_____ Date of Injury			Describe the nature of the injury. (ex. amputation, burn, cut, fracture):			
	_____ Date Employer Had Knowledge of the Injury						
	_____ Date Claim Admin. Had Knowledge of the Injury						
	_____ Initial Date Last Day Worked						
	_____ Initial Return to Work Date (if applicable)			Part(s) of body directly affected by the injury or illness. (ex. hand, arm, circulatory system):			
	_____ Employee Date of Death (if applicable)						
	_____ Time of Injury						
	_____ Time Employee Began Work						
	Pre-Existing Disability Code: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Describe the events that caused the injury. (ex. fell, operating machinery, chemical exposure):			
	Accident Premises Code: <input type="checkbox"/> Employer (E) <input type="checkbox"/> Lessee (L) <input type="checkbox"/> Other (X)			Name the object or substance that directly injured the employee. (ex. knife, floor, acid, oil):			
Accident Site Organization Name:							
Accident Site Street, City, State, & Postal Code:							
Accident Location Narrative (if no street address):			Specify activity the employee was engaged in when the event occurred. (ex. cutting metal plate for flooring) Indicate if activity was part of normal duties:				
Accident Site County/Parish:			Witness Name & Business Phone Number:				
MEDICAL	Initial Treatment Code (check one): <input type="checkbox"/> no medical treatment (0) <input type="checkbox"/> minor/on-site treatment (1) <input type="checkbox"/> clinic/hospital visit (2) <input type="checkbox"/> emergency care (3) <input type="checkbox"/> hospitalization > 24 hours (4) <input type="checkbox"/> future medical treatment/lost time anticipated (5)			Initial Medical Provider Name:		Managed Care Organization Name or ID Number:	
				Initial Medical Provider Physical Address, City, State, & Postal Code:		ICD Primary Diagnostic Code (if known):	
Preparer's Name & Title:		Preparer's Company Name:			Phone Number:		Date:

IAIABC FORM 1.2 (12/98)

**This section is to provide information valuable in handling this claim.
The Iowa Occupational Safety and Health Act**

The following is a summary of the recordkeeping, reporting and posting responsibilities of employers under Iowa's Occupational Safety and Health Act.

RECORDKEEPING REQUIREMENTS

Regulations issued under the Iowa Occupational Safety and Health Act of 1972 require establishments subject to the Act to maintain records of recordable occupational injuries and illness. Such records must consist of: (a) a log and summary of occupational injuries and illnesses and (b) a supplementary record of each occupational injury and illness.

LOG AND SUMMARY OF OCCUPATIONAL INJURIES AND ILLNESSES. Each recordable occupational injury and occupational illness must be entered on a log and summary of cases (OSHA Form No. 200) as early as practicable but no later than 6 working days after receiving information that a recordable case has occurred. A multi-unit employer may maintain the log and summary of occupational injuries and illnesses at a place other than the establishment if there is a copy of the log and summary available in the establishment complete and current to a date within 45 calendar days. If an equivalent of OSHA Form No. 200 is used, such as a printout from data-processing equipment, the information shall be as readable and comprehensible to a person not familiar with the data-processing equipment as the OSHA Form No. 200 itself. Logs must be kept current and retained for 5 years following the end of the calendar year to which they relate.

SUPPLEMENTARY RECORD OF OCCUPATIONAL INJURIES AND ILLNESSES. To supplement the Log and Summary of Occupational Injuries and Illnesses, each employer must have available a record for each occupational injury or illness at each establishment within 6 working days after receiving information that a recordable case has occurred, OSHA Form No. 101 may be used for this purpose. State of Iowa Form No. 14-0001 (7-99), workers' compensation or other reports are acceptable as records if they contain the information required on OSHA Form No. 101. These records must be available in the establishment without delay and at reasonable times for examination by representatives of the Iowa Division of Labor Services, the U.S. Department of Labor and the U.S. Department of Health, Education and Welfare. The records must be maintained for a period of not less than 5 years following the end of the calendar year to which they relate.

ANNUAL SUMMARY. Each employer subject to the recordkeeping requirements must prepare a summary of the occupational injury and illness experience of the employees in each of the employer's establishments at the end of each year based on the information contained in the log and summary of occupational injuries and illnesses for the particular establishment. OSHA Form No. 200 shall be used for this purpose. The summary shall be signed and posted in a place accessible to the employees no later than February 1 and shall remain in place until March 1. For employees who do not report to work at a single establishment, or who do not report to any fixed establishment on a regular basis, employers shall satisfy the posting requirement by presenting or mailing a copy of the annual summary during the month of February to all such employees who receive pay during that month. Summaries must be retained for 5 years following the end of the calendar year to which they relate.

EMPLOYEES NOT IN FIXED ESTABLISHMENTS. Employers of employees engaged in physically dispersed operations such as occur in construction, installation, repair or service activities who do not report to any fixed establishment on a regular basis but are subject to common supervision may satisfy the recordkeeping provisions with respect to such employees by:

(a) Maintaining the required records for each operation or group of operations which is subject to common supervision (field superintendent, field supervision, etc.) in an established central place;

(b) Having the address and telephone number of the central place available at each worksite; and

(c) Having personnel available at the central place during normal business hours to provide information from the records maintained there by telephone and by mail.

(Note: This regulation does not automatically apply to all construction, installation, repair or service activities. If in doubt about applicability to your operations, contact the Iowa Division of Labor Services.)

Records for personnel who do not primarily report or work at a single establishment, and who are generally not supervised in their daily work, such as traveling salespersons, technicians, engineers, etc., shall be maintained at the location from which they are paid or the base from which personnel operate to carry out their activities.

REPORTING REQUIREMENTS

Regulations issued under the Iowa Occupational Safety and Health Act require all employers subject to the Act to report in writing to the Iowa Workers' Compensation Commissioner any occupational injury or illness which temporarily disables an employee for more than three days or which results in permanent total disability, permanent partial disability, or death. State of Iowa Form No. 14-0001 is to be used, and is to be filed with the Iowa Division of Workers' Compensation within four days from such event when the injury or illness is alleged by the employee to have been sustained in the course of the employee's employment. A report to the Iowa Division of Workers' Compensation is considered to be a report to the Iowa Division of Labor Services. The Iowa Division of Workers' Compensation shall forward all such reports to the Iowa Division of Labor Services.

In addition, employers must report to the Iowa Labor Commissioner within 8 hours each accident or health hazard that results in one or more fatalities or hospitalization of three or more employees. The toll free number that is available 24 hours a day, including weekends and holidays, to use to report is 1-877-2-IA-OSHA (1-877-242-6742).

Those establishments selected to participate in the annual Occupational Injuries and Illnesses Survey will be required to prepare a report (OSHA Form No. 200-S) based on entries contained on the Log and Summary of Occupational Injuries and Illnesses.

POSTING REQUIREMENTS

The Iowa Occupational Safety and Health Act requires that employees be informed of the job safety and health protection provided under the Act. The poster, "Safety and Health Protection on the Job," is to be used for this purpose, and must be posted in a prominent place in the establishment to which the employees usually report to work. The poster briefly states the intent and coverage of the Act and the responsibilities of employers and employees to maintain safe and healthful working conditions.

EMPLOYERS WHO MUST KEEP OSHA RECORDS

Employers with 11 or more employees (at any one time in the previous calendar year) in the following industries must keep OSHA records. The industries are identified by name and by the appropriate Standard Industrial Classification (SIC) code:

- Agriculture, forestry, and fishing (SIC's 01-02 and 07-09)
- Oil and gas extraction (SIC 13 and 1477)
- Construction (SIC's 15-17)
- Manufacturing (SIC's 20-39)
- Transportation and public utilities (SIC's 41-42 and 44-49)
- Wholesale trade (SIC's 50-51)
- Building materials and garden supplies (SIC 52)
- General merchandise and food stores (SIC's 53 and 54)
- Hotels and other lodging places (SIC 70)
- Repair services (SIC's 75 and 76)
- Amusement and recreation services (SIC 79)
- Health services (SIC 80), and
- State and local government (Above SIC's plus 91-97).

If employers in any of the industries listed above have more than one establishment with combined employment of 11 or more employees, records must be kept for each individual establishment.

All employers, including small employers and those in exempted SIC's, must continue to meet the requirement to report fatalities or multiple (3 or more) hospitalizations and all occupational injuries or occupational illnesses that result in a workers' compensation case.

If an employer is notified in writing by the Bureau of Labor Statistics about having been selected to participate in a statistical survey, such employer, including small employers, and those in exempted SIC's, must maintain a log and summary of all occupational injuries and illnesses for that year. The notification will contain the necessary form and instructions to comply with the survey requirements.

The Iowa Workers' Compensation Act

The following is a summary of the recordkeeping and reporting responsibilities of employers under the Iowa Workers' Compensation Act.

RECORDS AND REPORTS

Every employer shall keep a record of all injuries sustained by employees in the course of their employment resulting in incapacity for longer than one day. An employer with notice or knowledge of an injury which temporarily disables an employee for more than three (3) days or results in permanent total disability, permanent partial disability or death is required to file a report with the Workers' Compensation Commissioner, on State of Iowa Form No. 14-0001, within four (4) days from such event when such injury is alleged by the employee to have been sustained in the course of employment.

All books, records and payrolls of an employer are required to be open for inspection by the Workers' Compensation Commissioner for purposes of administration of the Iowa Workers' Compensation Act.

The Workers' Compensation Commissioner may require an employer to appear and show cause why the employer should not be subject to a civil penalty of \$100.00 per occurrence for failure to comply with the reporting or inspection requirements. Upon hearing, if the facts indicate, the commissioner may enter an order requiring payment of such penalty. Unless voluntarily paid, the commissioner may petition the district court for entry of judgment on the order. The employer's insurance carrier shall be responsible in the same manner and to the same extent as the employer when a report of injury has been submitted to the employer's insurance carrier and not filed by them with the Workers' Compensation Commissioner.

The employer is required to furnish to an employee, on request, one statement of earnings, wages or salary for the year preceding the injury. An employer may be subject to a civil penalty of \$25.00 per offense for refusal to furnish such wage statement.

INSTRUCTIONS

An employer with notice or knowledge of an injury which temporarily disables an employee for more than THREE (3) days or results in permanent total disability, permanent partial disability or death is required to file a copy of this report with the Iowa DIVISION OF WORKERS' COMPENSATION within FOUR (4) days from such event when such injury is alleged by the employee to have been sustained in the course of the employee's employment. A report to the Iowa DIVISION OF WORKERS' COMPENSATION is considered to also be a report to the Iowa DIVISION OF LABOR SERVICES. The Iowa DIVISION OF WORKERS' COMPENSATION shall forward this report to the Iowa Division of Labor Services. Employers should also report ALL injuries to their insurance carrier. ALL REPORTS MUST BE FILLED IN COMPLETELY AND SIGNED. PLEASE TYPE OR PRINT LEGIBLY.

This form contains all items requested on OSHA form No. 101, "Supplementary Record of Occupational Injuries and Illness."

THE INFORMATION PROVIDED WILL BE OPEN FOR PUBLIC INSPECTION UNDER Iowa Code § 22.11.



WORKERS COMPENSATION COST CONTAINMENT INITIATIVES

Argent participates in several medical cost containment programs. The use of these programs helps reduce your workers' compensation expenses. A brief summary of each program is outlined below.

If you have any questions about any of the programs we offer, please call your dedicated claim representative at 888-236-5008.

PHARMACY PROGRAM

This program is designed to provide discounts on workers' compensation prescriptions submitted by your injured worker's. This service is provided by a national pharmaceutical management company using a network of retail pharmacies.

How the program works:

1. The injured worker files a workers' compensation claim with employer, seeks medical treatment, and receives a prescription from a provider.
2. The injured worker presents the prescription along with the temporary ID form to a participating pharmacy where the claim is electronically submitted by the pharmacy to our vendor.
3. Once Argent receives notification of the claim from the employer, an employee ID drug card is issued, along with a list of participating pharmacies and instructions on the use of the program.
4. The injured worker presents the ID drug card to a participating pharmacy for any workers' compensation prescriptions.
5. High cost/long term use medications are conveniently supplied through our vendor's mail service pharmacy.

DIAGNOSTIC TESTING PROGRAM

Using the services of a diagnostic management vendor, we can save money on diagnostic tests (i.e., CT scans, MRIs, EMGs, etc.) the treating provider orders for injuries an employee sustains in a work-related incident. Our vendor will schedule the test then notify the injured worker of the date, time, and location. Once the test is performed the films/x-rays will be forwarded to the referring provider.

To make this program successful, we ask that you encourage your employees to contact their Argent claim representative as soon as their provider orders a diagnostic test. We will handle it from there.

MEDICAL COST CONTAINMENT

Strong medical management brings about the early and safe return to work of your employees and reduces claim costs. In order to control the medical bill costs, we contract with a medical bill review service. All of our medical provider charges (hospital, physician, physical therapist, chiropractor, and pharmaceutical) are verified for the appropriateness of the charge, and to determine if they adhere to state mandated fee schedules or local usual and customary (U&C) reimbursement levels. This process often reduces our medical expenses by 10-30%.

Another way we are containing costs is through the use of PPO Networks. The Preferred Providers have agreed to discount their billings to the agreed upon PPO Network rates for our insured's injured workers. This in turn keeps your premium costs down.

Your support in encouraging your injured workers to use a PPO provider is important. It sends an important message to the medical care providers that we support them in their effort to offer quality, cost effective care to patients.

For a list of PPO's in your area, please visit our website, www.argentworkerscomp.com for a link to the PPO Directory.

QUALITY MEDICAL CARE (Applicable in Indiana and Iowa only)

As your workers' compensation insurer, we share your goal of providing quality medical care to your injured workers so they may return to the workforce as soon as possible. In Indiana and Iowa, the employer and its insurance carrier have the responsibility for providing reasonable and necessary medical care when there is an injury, in addition to selecting the provider. In other words, it is the employer and insurance carrier who select the provider to treat an injury, not the injured worker. If the employee refuses to accept medical services as instructed by the employer/insurance carrier, the right to receive compensation may be suspended during the period of refusal.

It has been our experience that one of the most effective ways to carry out our mutual responsibilities under the Indiana and Iowa Workers' Compensation Laws for an injured worker, is for you, as an employer, to designate a company physician/clinic who is authorized to treat work related injuries. This designation should be part of our internal procedure for reporting work related injuries. Each employee should be instructed, particularly when first hired, on how to report an on-the-job injury and what physician/clinic is authorized for treatment. It should be made clear that except in cases of an emergency, no other medical or chiropractic care is authorized and charges incurred for those services will not be honored. Many of our employers put this policy in writing and have the employee sign and date this document.

There are many benefits to this policy. First, injured workers know exactly where to go for medical care when needed. Second, a good working relationship is established between the physician, you as an employer, and us as an insurance carrier. We find we get prompt answers to our questions and are able to better manage both medical costs and claims for weekly benefits. Referrals, particularly when an independent medical exam is needed, are greatly simplified. Where rehabilitation is needed, company physicians can assist our rehabilitation nurses and our vocational counselors.

We will be happy to work with you in designating a company physician/clinic and helping you implement this program. Please feel free to call the Workers' Compensation Claim Department with any questions or comments.

Argent Workers' Compensation Prescription Information

Employer:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

Employee Name:	
Group#:	10602464
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	014211
Day supply is limited to 30 days for a new injury.	
myMatrixx Help Desk: (877) 804-4900	

Employer Signature:	Phone:	Date:
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Employee:

Argent has partnered with **myMatrixx** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 5 to 15 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 60,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist: Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only. Document only valid if signed and dated by employer above.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900

Joe Sample
123 2nd Street
Anywhere, FL 33635

Thu May 24 12:50 EDT 2007

RE: Argent Workers' Compensation Prescription Drug Program

Dear Joe Sample,

Argent has contracted with myMatrixx to have prescriptions for your work related injury filled at no expense to you.

What is Covered?

Only medication(s) prescribed by your authorized treating physician for your work-related injury will be approved. This program does not cover prescriptions for any other medical condition.

What do I do?

After receiving your prescription from your workers' compensation physician, visit any network pharmacy and present your prescription and prescription card. Your pharmacy will submit the required information to myMatrixx. You do nothing else.

In the event there is a problem processing your prescription(s) please call or have the pharmacist call myMatrixx 24 hours a day, 7 days a week at 877-804-4900.

Which pharmacies can I use?

Your prescription Card is honored at over 60,000 pharmacies nationwide. Here are just a few in your area. For more network pharmacy locations, please call 877-804-4900.

Walgreens Pharmacy
1211 Hillsborough Ave.

Publix Pharmacy
8975 Race Track Rd.

Walgreens Pharmacy
7925 Gunn Highway

CVS #5196
11670 Country Way Blvd.

Publix Pharmacy
12139 W. Linebaugh Ave.

Kash N Kerry Pharmacy
10617 Sheldon Road

CVS Pharmacy
8801 W. Linebaugh Ave.

Publix Pharmacy
7835 Gunn Highway

CVS Pharmacy
7920 Gunn Highway



Answers to your questions.

1. What is this card?

This card is for your workers' compensation prescription needs. Please take this card to the pharmacy when you are filling medications for your work-related injury.

2. Why did I receive this card?

You received this card due to an injury that occurred on the job.

3. What if I am not currently taking any medications due to the injury?

Please put the card in a safe place in case you start taking medications for your current injury.

4. When should I use this card?

Anytime you need to fill a medication for your work-related injury.

5. Are all medications pre-approved?

Your insurance company may have pre-selected medications that will go through without authorization. If you drop off a prescription at the pharmacy and it rejects for any reason the pharmacy should call us and we will call your insurance co. for approval. If you would like to know the types of medications that are pre-approved before going to the pharmacy, please call 877-804-4900 and a customer service rep will be happy to assist you.

6. Can my family members use this card?

No, this is only for your work-related injury.

7. What should I do if there is a problem with my card when I take it to the pharmacy?

Your pharmacy should call us with any problems they are having with the card. If for ANY reason they do not call us, or if you have any questions regarding your work-related medications, please call our customer service team at 877-804-4900.

8. Are you my workers' compensation insurance company?

No, we were contracted by your workers' compensation insurance company to handle all of your work-related prescription needs.

9. What happens if my medication doesn't provide any relief from my symptoms or pain?

You should contact your doctor or our pharmacist to verify that the medication prescribed for your pain is the most appropriate for your condition.

10. Should I tell my doctor about other medications I am taking not related to my injury?

Yes, it is very important that your physician and pharmacist know ALL the medications you are currently taking. Some medications may counter the effect of other medications you are taking and some may even be harmful or life threatening when taken together. If you are unsure of your current medications, call our myMatrixx pharmacist.

11. Can I talk to one of your pharmacists if I have a question?

Yes, our pharmacists are available to answer all of your medication related questions.

For any additional questions please contact myMatrixx at 877-804-4900

Patient - You must present this identification card each time you go to the pharmacy for your authorized prescriptions only. If you are denied medication, please call.

Pharmacist - For questions, please call 24 hours a day, 365 days a year. Dispensed quantity of medications is limited to a 30 day supply. Do not send patient home without first contacting myMatrixx for all rejections.

Note: Insurance company has pre-approved certain medications for this patient; these medications will process without an authorization. Any medications that are rejecting, must be called into myMatrixx for authorization.

**Any questions or problems, please call:
877.804.4900**

**AUTHORIZATION TO RELEASE INFORMATION
REGARDING CLAIMANTS SEEKING WORKERS' COMPENSATION BENEFITS**

Name of Patient: _____

Date of Birth: _____

Social Security No: _____

SECTION I. AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR REDISCLOSURE

I authorize _____

to disclose and deliver to: Argent, 1900 South 18th Avenue, West Bend, WI 53095

the following information related to me: Any and all information EXCEPT substance abuse (drug or alcohol), mental health, and AIDS-related information, unless specifically authorized to be released in section II of this form.

NOTE: If the information includes mental health treatment, substance abuse treatment, or HIV-related information it will not be released unless the undersigned patient agrees to the release on the reverse side of this form.

I understand the information is being disclosed and may be used only for legal and/or litigation purposes relating to claims and/or suit against _____

I understand that this Authorization may be used to obtain information from health care providers, schools, former and current employers, providers of vocational rehabilitation services, the Social Security Administration, and the Iowa Department of Workforce Development. I understand that I have a right to inspect the disclosed information at any time. This authorization is effective until the conclusion of a contested case on the claim. I understand that I may revoke this Authorization, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider or record keeper. I also understand that if I revoke, the revocation will take effect on the day it is received in writing by the entity from whom disclosure is sought.

I understand that the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations.

Iowa and Federal law provide that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization, except as indicated below. I understand that the Recipient of this Authorization, WITHOUT FURTHER AUTHORIZATION, may redisclose this information to:

Parties and their legal counsel, insurers, experts, potential experts, but only after they have been advised of their obligations under the law and this authorization, including the prohibition against redisclosure of this information; Agents, employees or representatives of the parties, but only after they are involved in conducting the prosecution or defense of the case, and only after they have been advised of their obligations under the law and this authorization, including the prohibition against redisclosure of this information; Administrative agency and court officials hearing the claim, and their support staff.

I SPECIFICALLY AUTHORIZE AND CONSENT TO ANY SAID DISCLOSURE AND REDISCLOSURE DESCRIBED ABOVE.

Claimant or Legal Representative

Date

Printed Name and Relationship of Claimant's Legal Representative

SECTION II. SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT OR AIDS-RELATED INFORMATION

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and/or AIDS-related information. I SPECIFICALLY AUTHORIZE the release of confidential information relating to: [Place "YES" or "NO" in ALL applicable boxes:]

- _____ Substance Abuse (Drug or Alcohol) information from all health care providers and facilities and any other person or entity in possession of records concerning me.
- _____ Mental Health information from all health care providers and facilities and any other person or entity in possession of records concerning me.
- _____ HIV or AIDS-related information, Diagnosis, and test results from all health care providers and facilities and any other person or entity in possession of records concerning me.

Furthermore, I SPECIFICALLY AUTHORIZE disclosure and re-disclosure of this confidential information to all of the persons referred to in the REDISCLOSURE Section I.

In order for the above information to be released you must sign here AND at the end of Section I

Signature of Claimant or Legal Representative

Date

Street Address

City/State/ Zip Code

Printed Name and Relationship of Claimant's Legal Representative

Federal and/or State law specifically require that any disclosure or REDISCLOSURE of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

See also Chapter 228 of the Iowa Code and Section 141.23(3) of the Iowa Code and other applicable laws.

14-0043 (11/04) This form may be used in connection with claims under the jurisdiction of the Iowa Workers' Compensation Commissioner.



**Regardless of normal job duties, light duty work will be accommodated.
Please prepare restrictions below:**

ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD		Claim No. _____																									
Patient's Name (First)	(Middle Initial)	(Last)	Date of Injury/Illness																								
TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK																											
Diagnosis/Condition (Brief Explanation)																											
I saw and treated this patient on _____ and based on the above description of the patient's current medical problem: (date)																											
1. <input type="checkbox"/> Recommend his/her return to work with no limitations on _____ (date)																											
2. <input type="checkbox"/> He/She may return to work on _____ capable of performing the degree of work checked below with the following limitations: (date)																											
<input type="checkbox"/> Sedentary Work. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met. <input type="checkbox"/> Light Work. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls. <input type="checkbox"/> Light Medium Work. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds. <input type="checkbox"/> Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds. <input type="checkbox"/> Medium Heavy Work. Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds. <input type="checkbox"/> Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.		1. In an 8 hour work day patient may: a. Stand/Walk <input type="checkbox"/> None <input type="checkbox"/> 1-4 hours <input type="checkbox"/> 4-6 hours <input type="checkbox"/> 6-8 hours b. Sit <input type="checkbox"/> 1-3 hours <input type="checkbox"/> 3-5 hours <input type="checkbox"/> 5-8 hours c. Drive <input type="checkbox"/> 1-3 hours <input type="checkbox"/> 3-5 hours <input type="checkbox"/> 5-8 hours 2. Patient may use hand(s) for repetitive: <input type="checkbox"/> Single Grasping <input type="checkbox"/> Pushing & Pulling <input type="checkbox"/> Fine Manipulation 3. Patient may use foot/feet for repetitive movement as in operating foot controls: <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Patient is able to: <table style="width: 100%; border: none;"> <thead> <tr> <th></th> <th style="text-align: center;">Frequently</th> <th style="text-align: center;">Occasionally</th> <th style="text-align: center;">Not At All</th> </tr> </thead> <tbody> <tr><td>a. Bend</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>b. Squat</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>c. Climb</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>d. Twist</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>e. Reach</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table>			Frequently	Occasionally	Not At All	a. Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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d. Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
e. Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
Other Instructions and/or Limitations Including Prescribed Medications:																											
These restrictions are in effect until _____ or until patient is re-evaluated on _____ (date) (date)																											
3. <input type="checkbox"/> He/She is totally incapacitated at this time. Patient will be re-evaluated on _____ (date)																											
Physician's Signature		Date																									
Print name:		Phone number																									
Facility Name:																											

Loss Control Services

Argent offers a comprehensive, proactive approach to managing your workers compensation exposures. Our goal is to enhance the current safety culture within your organization. This is a sample of the variety of services Argent's Loss Control Department may provide.

- Comprehensive assessment of exposures specific to the operations that may impact workers safety:
 - Assessment of established controls for the physical environment;
 - Assessment of management approach to safety;
 - Employee responsibilities for safety;
 - In depth analysis of losses; and
 - Identification of loss drivers.
- Development of a comprehensive, collaborative safety plan to address those factors affecting the workers compensation program.
- Onsite and job site specific assessments of physical exposures:
 - Machine guarding;
 - Ergonomics;
 - PPE use; and
 - Identification of hazards in the workplace.
- Training of management, supervisors, and key personnel:
 - Accident investigation;
 - Costs and effects of workers compensation insurance;
 - Transitional return to work programs;
 - Safety roles;
 - Accountability; and
 - Loss drivers, observations, and opportunities to improve operational safety.

- Development of specific safety recommendations based on observations and interactions with management and employees.
- Hands-on approach for assisting in the development and implementation of safety recommendations.
- Personalized consultation for management based on the customer's individual needs.
- Hands-on assistance with developing:
 - Transitional return to work program;
 - Slip/fall prevention programs;
 - Safe patient/resident handling programs for medical facilities;
 - Effective safety committee;
 - Ergonomic committee;
 - Injury review committee; and
 - Fleet safety programs.
- Periodic service review meetings are provided to assure your needs are being addressed.
- Resources available for OSHA programs, training videos, and training documents.

The Silver Lining[®] ADVANTAGE

With the **Silver Lining Advantage**, you benefit from the expertise and guidance of qualified nurse case managers. Using their experience in the medical field, these professionals carefully examine the medical aspects of your company's workers' compensation claims to reduce the claim costs and the duration of the disability. This not only helps control the cost of these claims, it results in a more positive outcome for your employees and your company.

The **Silver Lining Advantage** program offers a variety of services customized to help your company reduce your workers' compensation claim costs.

These services include:

- Reducing medical and disability costs through a collaborative approach;
- Expert medical resources available to all accounts;
- An average of 24 years of experience for each member of your nurse case manager team;
- A focus on building relationships with the medical community; and
- The ability to capture and report cost savings.



ARGENT- Claim Practices

Initial Contacts – Within 24 hours of receipt of claim, contacts made to employee, employer and medical provider.

Investigation – Investigation of claims is to include, but not limited to: recorded statements of employees and witnesses, requesting prior and present medical records, obtaining job descriptions or videos, subrogation potential, Independent Medical Evaluations, and other investigative services when necessary.

Transitional Return to Work - Will be addressed immediately. Consult with employer as to availability and the importance of prompt return to work.

Reserves - Set for known and probable exposures based on the facts of the case. If the reserves exceed \$25K the Claims Representative will complete a reserve letter explaining the basis for the numbers and send to Employer, Agent, Underwriter, Loss Control and Claims Assistant Vice President.

Denials – After claim is denied, it will remain open based on the merits of the case. Upon denial, letters will be sent from Claims Representative to employee, employer, and medical provider.

Dedicated Claim Team- Lost time and medical only claim professionals will be assigned to your account.

Managed Care Program- We have a team of highly knowledgeable nurses who are proficient in treatment protocols and in getting the right care at the right time to injured workers.

Narcotic Program – Comprehensive internal program to mitigate the use of narcotic medications through education, early intervention and evaluation to facilitate favorable outcomes.

Subrogation

What is subrogation? Subrogation is process by which an insured/insurer can recover the amount paid on a claim from a legally-liable party. The workers' compensation policy grants the insurer subrogation recovery rights.

Why is subrogation important to your business? Subrogation allows the first- party payer (typically the insurer) to recover money paid from the liable party, thereby reducing the total costs incurred, as well as your experience modifier. This means your premium will not increase if an employee is injured in an accident for which someone else is liable.

How can you help our subrogation efforts to maximize recoveries?

- Discuss/explain the subrogation process in your safety committee meetings.
- Advise employees who work at or travel to other worksites to notify you and the off-premises property owner of any unsafe exposures, such as accumulated snow/ice, cluttered walkways, unsafe stairways, generally slippery floors, poor lighting, etc.
- Educate employees who work at or travel to other worksites to take photographs of off-premises accidents, such as motor vehicle accidents, falls from ladders, construction scene accidents, etc.
- For construction site accidents, provide the name of the general contractor and a list of all subcontracts involved.
- Advise your employees to immediately notify the property owner when/where the accident occurred.
- Report the workers' compensation claim to Argent immediately; subrogation investigations are extremely time sensitive.
- When applicable, provide Argent or our representative with copies of rental agreements, contracts, owner's manuals, maintenance records, photographs, diagrams, invoices, certificates of insurance, etc.
- Do not discard or repair any equipment that may have led to your employee's injury (i.e., broken ladder). The item may need to be inspected/tested by an independent engineer.

Subrogation considerations:

- Would the at-fault party pursue a liability claim against your company if the tables were turned?
- If the injury to your employee and its effect on your employee's family were life changing, would that influence your decision to subrogate?
- Should your insurance premiums increase because of exposures you can't control?

Management Accident Investigation Report

To Be Completed By One Of The Following: Supervisor / Plt Manager / HR. Director

Employee	Dept.	Job Title
Shift:	Date of Injury	Time AM or PM
Location of Incident		
Date Reported / /	Reported to Whom?	
Time Reported		
NAME OF WITNESS	DEPARTMENT/ADDRESS	PHONE
(1)		
(2)		
Have witnesses fill out separate forms and give attach.		
1. What was employee doing when injured? BE SPECIFIC		
2. How did the injury/illness occur?		
3. Was employee performing function alone? <input type="checkbox"/> yes <input type="checkbox"/> no		
Employee was assisting with the operations?		
4. Did injury occur because of: Failure to follow safety rules <input type="checkbox"/>		
Failure to use safety device <input type="checkbox"/> Other <input type="checkbox"/>		
5. How long has employee been doing this job? (days, months, years)		
6. What safety equipment is required on the job the employee was performing?		
7. Was the employee using all required safety equipment? Yes <input type="checkbox"/> No <input type="checkbox"/>		

8. If No, which specific personal protective equipment was not used & why?

9. Does an unsafe condition exist that contributed to the cause, if so, what is that condition?

10. How could the accident have been prevented? BE SPECIFIC

RECOMMENDED ACTION			Person Responsible	Assigned Date/Completed Date
Re-instruction	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____/_____
Equipment repair/replacement	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____/_____
Reduce Clutter	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____/_____
Improve design/construction	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____/_____
Workstation Modification	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____/_____
Discipline of person(s) involved	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____/_____
Other				

Signature of Person Completing Investigation: _____

Date: _____

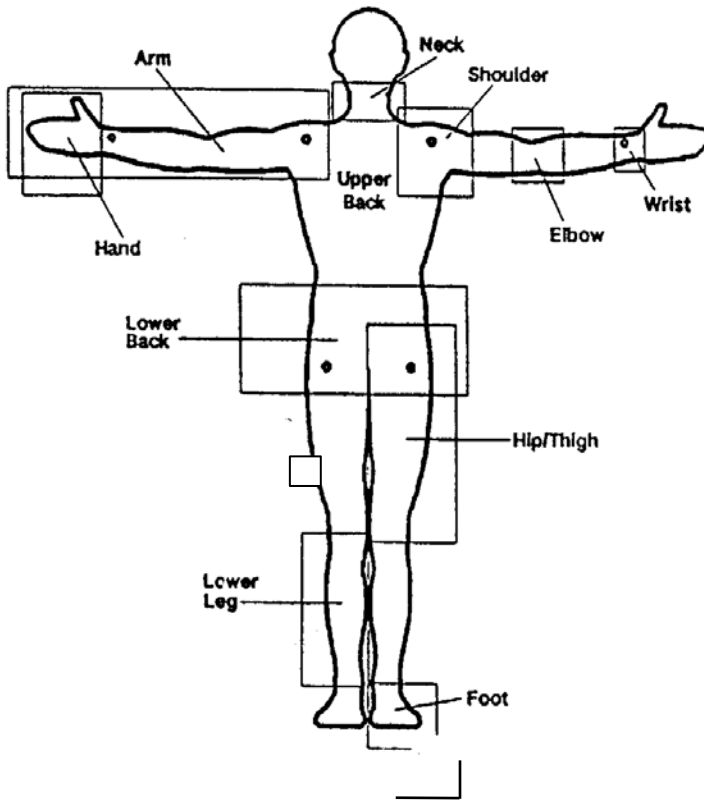
Employee Accident Report

Name: _____ Accident Location: _____

Date of Injury: _____ Time: _____ a.m. ☐ p.m. ☐ Date Reported: _____

Witnesses: _____

Accident Description: _____

Injured Area	Indicate Area of Injury	Type of Injury
1 <input type="checkbox"/> Head		1 <input type="checkbox"/> Abrasion
2 <input type="checkbox"/> Eye: L / R		2 <input type="checkbox"/> Amputation
3 <input type="checkbox"/> Shoulder L / R		3 <input type="checkbox"/> Bite: _____
4 <input type="checkbox"/> Arm L / R		4 <input type="checkbox"/> Bruise
5 <input type="checkbox"/> Elbow L / R		5 <input type="checkbox"/> Burn
6 <input type="checkbox"/> Wrist L / R		6 <input type="checkbox"/> Concussion
7 <input type="checkbox"/> Hand L / R		7 <input type="checkbox"/> Cut / Laceration
8 <input type="checkbox"/> Finger: Specify _____		8 <input type="checkbox"/> Foreign Body
9 <input type="checkbox"/> Back		9 <input type="checkbox"/> Fracture
10 <input type="checkbox"/> Chest		10 <input type="checkbox"/> Hearing Impaired
11 <input type="checkbox"/> Abdomen		11 <input type="checkbox"/> Infection
12 <input type="checkbox"/> Pelvis		12 <input type="checkbox"/> Pain: _____
13 <input type="checkbox"/> Hip L / R		13 <input type="checkbox"/> Puncture
14 <input type="checkbox"/> Leg L / R		14 <input type="checkbox"/> Rash/Derm.
15 <input type="checkbox"/> Knee L / R		15 <input type="checkbox"/> Respiratory
16 <input type="checkbox"/> Ankle L / R		16 <input type="checkbox"/> Strain/Sprain
17 <input type="checkbox"/> Foot L / R		17 <input type="checkbox"/> Other: _____
18 <input type="checkbox"/> Toe: Specify _____		_____
19 <input type="checkbox"/> Other: _____		_____
_____	_____	_____
_____	_____	_____



Have you ever injured this body part before? _____ if so, when? _____

Are you currently receiving medical treatment for the prior injury? _____

What do you believe caused this accident? _____

What can be done to prevent this from happening in the future? _____

Signature: _____

Date: _____

WITNESS REPORT OF INCIDENT

Name: _____ Injured Employee Name: _____

Date of Injury: _____ Time of Accident: _____ (AM/PM)

Location where injury occurred:

Describe activity prior to the accident:

Describe the accident:

What do you believe caused the accident:

What part of the body was injured? _____

What do you think could prevent this type of accident from occurring again?

Signed: _____ Date: _____

Temporary Work Schedule

DEFINITION: A form used by an employee returning to work in the Temporary Work Program.

POLICY

Every employee returning to temporary restricted work duty must use a Temporary Work Schedule. It is the employee's immediate supervisor's responsibility to thoroughly explain the use of the Temporary Work Schedule. The Temporary Work Schedule must be completed daily.

The temporary tasks assigned to you may or may not be normal and customary job duties.

The **employee's responsibility** to complete:

- Restrictions
- Symptom Control Techniques
- Date
- Hours Worked - Log Breaks, Rest and Lunch
- Duties Performed
- Employee Comments
- Employee Signature

The **supervisor's responsibility** to complete:

- Supervisor's Comments (document discussion of problems and actions taken)
- Supervisor's Signature

*The supervisor and employee must sign schedule daily.

Supervisors turn Work Schedule into Human Resources Department at end of week.

Employee should retain a copy for their file.

The Human Resources Department will forward copy to Argent Claims Representative and, if necessary, to treating physician

Temporary Work Schedule

Name:			Restrictions:	
Supervisor:			Symptom Control Techniques:	
Date	Work Log (include breaks/lunch)	Tasks Assigned/Completed	Employee Signature and Comments	Supervisor Signature and Comments
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

I clearly understand, take responsibility for, and acknowledge the limitations my physician, Dr. _____ has placed on me while participating in this Temporary work program.

(Signature and Date)



Argent- A Division of West Bend Mutual

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LC208- Temporary Work Schedule- Rev 9-16