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Kentucky Worker's Compensation Claim Kit

ARGENT®
A DIVISION OF WEST BEND

– 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
- Upper right leg
- Right forearm
- 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
- Lifting equipment
- They hurt their back lifting product

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

- Lifting an air conditioner
- Carrying magazines
- Pushing a cart
- 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
- Bruise
- Fracture
- 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).

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD TO CHECK IF APPROPRIATE ⑥ SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
		Assured NL Insurance Services Inc. DBA: Risk Management Services Company P.O. Box 22989 Louisville, KY 40252 Phone 502-326-5900 Fax 502-326-5909

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
		45-2712519

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX M MALE F FEMALE U UNKNOWN	MARITAL STATUS U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN	OCCUPATION/JOB TITLE EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

RATE PER:	DAY / WEEK / MONTH / OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? YES / NO DID SALARY CONTINUE? YES / NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	AM / PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED	AM / PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE	PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? YES / NO WERE THEY USED? YES / NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

FORM 106
ADOPTED JULY 2003

COMMONWEALTH OF KENTUCKY
OFFICE OF WORKERS' CLAIMS
657 Chamberlin Avenue
FRANKFORT, KY 40601

MEDICAL WAIVER AND CONSENT

I, _____ having filed a claim for workers' compensation benefits, do hereby waive any physician-patient, psychiatrist-patient, or chiropractor-patient privilege I may have and hereby authorize any health care provider to furnish to myself, my attorney, my employer, its workers compensation carrier or its agent, the Division of Workers' Compensation Funds, the Uninsured Employers' Fund, or Administrative Law Judge any information or written material reasonably related to my work-related injury occurring on or about _____ any medical information relevant to the claim including past history of complaints of, or treatment of, a condition similar to that presented in this claim or other conditions related to the same body part.

Such information is being disclosed to the purpose of facilitating my claim for Kentucky workers' compensation benefits.

I understand I have the right to revoke this authorization in writing at any time, by sending written notification to each individual health care provider, but such revocation will not have any affect on actions taken prior to revocation. Moreover, inasmuch as KRS 342.020(8) requires a medical waiver to be executed, revocation may result in suspension or delay of the workers' compensation claim.

I understand that no medical provider may condition treatment or payment on whether I sign this medical waiver; however, I further understand that failure to sign this medical waiver may result in suspension or delay of the workers' compensation claim.

I understand that the information used or disclosed pursuant to this medical waiver may be subject to re-disclosure by the recipient.

This authorization shall remain valid for 180 days following its execution. A photocopy of the authorization may be accepted in lieu of the original.

The authorization includes, but is not restricted to, a right to review and obtain all copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

Signed at _____, Kentucky, this _____ day of _____, 20_____.

_____
Signature of Patient Or Personal Representative

Social Security Number: _____

_____
Witness Signature

_____
Description Of Personal Representative's Authority

KENTUCKY WORKERS' COMPENSATION AND HIPAA

On April 14, 2003, the federal Health Insurance Portability and Accountability Act [HIPAA] privacy regulation will take effect. This regulation limits the situations in which medical providers may release patient information, unless the information is necessary for the purpose of treatment, payment, or health care operations. Moreover, it is important to note that disclosures for workers' compensation are in most instances exempt from HIPAA privacy requirements. The exact wording is as follows: "A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation…"

Since HIPAA defers to state law regarding disclosures relating to workers' compensation, it is important for claimants and medical providers to know what Kentucky law requires for disclosure of patient information. An employee who reports a work injury or who files for workers compensation benefits must "execute a waiver and consent of any physician-patient, psychiatrist-patient, or chiropractor-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation." KRS 342.020 (8). The reverse side of this Form 106 is the waiver and consent that each employee must sign. Kentucky law further states that once this Form 106 is signed, any health care provider "shall, within a reasonable time after written request by the employee, employer, workers' compensation insurer [or its agent or assignee], special fund, uninsured employers fund, or the administrative law judge, provide the requesting party with any information or written material reasonably related to any injury or disease for which the employee claims compensation."

Once the Form 106 is signed, health care providers may disclose information as set out in Kentucky law. Another section of the regulation allows release of information pursuant to an administrative or judicial order or subpoena, provided that there has been a reasonable effort to notify the injured worker [or his attorney] that such a request has been made. Should there be questions regarding disclosures pursuant to this form, appropriate legal counsel should be consulted or you can contact the Office of Workers' Claims at 800 554-8601.

Form 113
Designation of Physician
Revised 03-12-03

Two-Sided Form

COMMONWEALTH OF KENTUCKY
OFFICE OF WORKERS' CLAIMS
Claim No. _____

NOTICE OF DESIGNATED PHYSICIAN

EMPLOYEE: _____
Name

_____
Street Address

_____ ( ) _____
City, State, Zip Telephone Number

_____ _____
Date of Birth Social Security Number

EMPLOYER AT TIME OF INJURY OR LAST EXPOSURE:

_____
Name

_____
Street Address

_____
City, State, Zip

NATURE OF INJURY OR OCCUPATIONAL DISEASE: _____

_____

DATE OF INJURY OR LAST EXPOSURE: _____

FIRST DESIGNATED PHYSICIAN:

_____
Name

_____
Street Address

_____ ( ) _____
City, State, Zip Telephone Number

Accepted by: _____

MEDICAL INFORMATION RELEASE: I hereby waive any privilege I may have to restrict the release of information or written material reasonably related to the work-related injury/disease for which I have sought treatment, and I consent to the release of this information or written material to the medical payment obligor, my employer, Special Fund, Uninsured Employers' Fund, or attorneys representing me or any of the parties named above.

_____ _____
Date Employee Signature

MEDICAL PAYMENT OBLIGOR:

_____
Name Of Obligor

_____
Representative

_____
Street Address

_____ ( ) _____
City, State, Zip Telephone Number

This form identifies the designated physician and must be returned to the medical payment obligor within ten (10) days after treatment begins. An identification card will be provided to the employee, and that card should be presented when medical treatment is required.

Notice: The Workers' Compensation Act requires the employer to pay for the medical services reasonably necessary for cure and relief from the effects of a workplace injury or disease.

The employee may choose the physician (including chiropractors, etc.) who treats him as "designated physician." The designated physician is responsible for the coordination of the employee's medical care and may refer the patient to consulting or treating physicians as required. Except in an emergency, all treatment must be performed by or on referral from the designated physician. The employee may not change his designated physician more than once without the medical payment obligor's consent.

Inquiries shall be made to the listed representative of the medical payment obligor.

This form is not advance authorization from the workers' compensation medical payment obligor for medical services.

Form 114

KENTUCKY DEPARTMENT OF WORKERS CLAIMS

Frankfort, Kentucky 40601

REQUEST FOR PAYMENT FOR SERVICES OR REIMBURSEMENT FOR COMPENSABLE EXPENSES

TO BE FILED WITH THE RESPONSIBLE EMPLOYER OR ITS PAYMENT OBLIGOR

① Name, address and Workers Compensation claim number of Employee for whom services were provided or expenses incurred:

_____

_____

② Specific type and dates of service(s) provided:

Date(s)	Type of Service(s)

③ Name and address of physician who ordered services: (include written authorization if available)

_____

④ Reasonable value of services, including method of computation: $_____: _____

_____

⑤ Other expenses incurred for cure or relief of a work injury or occupational disease(s):

Date	Description of Expense(s)	$ Amount	If mileage, no. of miles
-------	---------- Total	$:	Miles:

Please attach receipts for all purchased items.

Certification:

I hereby certify that the above services were performed or expenses were incurred for the cure or relief of a work injury or occupational disease sustained by the above employee.

Witness: _____ _____

(Name of Person requesting payment)

Date: _____ Address: _____

Phone no: _____

NOTICE:

Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

COMMONWEALTH OF KENTUCKY
WORKERS' COMPENSATION NOTICE

Employees of this business are covered by the Kentucky Workers' Compensation Act (KRS Chapter 342). Conspicuous posting of this Notice is required by law.

Employer Name: _____
Address: _____
Workers Compensation Carrier
(or third party administrator): _____
Policy #:_____, effective _____ to _____
Address: _____
Telephone: _____, Contact Person _____

EMPLOYEES: IF INJURED – NOTIFY your supervisor IMMEDIATELY; when possible Notice should be in writing. FAILURE to notify your supervisor could result in denial of benefits. OBTAIN MEDICAL CARE. Your employer must pay for ALL NECESSARY MEDICAL CARE to treat a workplace injury. The employee may select the physician or medical facility to render care. If the employer is enrolled in an approved Managed Care Plan employee selection of physicians is LIMITED to the Approved Provider Network, except in certain emergencies. FOR INJURIES REQUIRING CONTINUING CARE the EMPLOYEE MUST DESIGNATE A TREATING PHYSICIAN, a form to do so will be furnished by your employer or its insurance carrier.

This employer IS ☐ IS NOT ☐ participating in a Managed Care Plan for medical care. The name of the Managed Care Plan is _____, its representative is _____, phone number _____.

DISABILITY BENEFITS to replace wages lost due to a workplace injury are payable under the Workers Compensation Act after seven (7) day of disability. A CLAIM MUST BE filed with the Department of Workers' Claim WITHIN TWO YEARS of the date of injury, or last payment of temporary total disability benefits.

NEED ASSISTANCE? Contact your employer's claim representative. If your questions about workers' compensation rights are not promptly answered call THE KENTUCKY DEPARTMENT OF WORKERS CLAIMS at 1-800-554-8601 to speak to an Ombudsman or Workers' Compensation Specialist.

EMPLOYER SUPERVISORS – NOTIFY MANAGEMENT IMMEDIATELY OF ALL INJURIES SO THAT TIMELY REPORT CAN BE MADE AS REQUIRED BY LAW.

04/09/09

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.

myMatrixx™
good medicine for business

P.O. Box 274070
Tampa FL • 33688
877.804.4900

ARGENT™
A DIVISION OF WEST BEND

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.

CVS #5196
11670 Country Way Blvd.

CVS Pharmacy
8801 W. Linebaugh Ave.

Publix Pharmacy
8975 Race Track Rd.

Publix Pharmacy
12139 W. Linebaugh Ave.

Publix Pharmacy
7835 Gunn Highway

Walgreens Pharmacy
7925 Gunn Highway

Kash N Kerry Pharmacy
10617 Sheldon Road

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

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 _____ (date) and based on the above description of the patient's current medical problem:

1. ☐ **Recommend his/her return to work with no limitations on** _____ (date)

2. ☐ **He/She may return to work on** _____ (date) **capable of performing the degree of work checked below with the following limitations:**

- ☐ **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.
- ☐ **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.
- ☐ **Light Medium Work.** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.
- ☐ **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.
- ☐ **Medium Heavy Work.** Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.
- ☐ **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
      ☐None ☐1-4 hours ☐4-6 hours ☐6-8 hours
   b. Sit
      ☐1-3 hours ☐3-5 hours ☐5-8 hours
   c. Drive
      ☐1-3 hours ☐3-5 hours ☐5-8 hours
2. Patient may use hand(s) for repetitive:
   ☐Single Grasping
   ☐Pushing & Pulling
   ☐Fine Manipulation
3. Patient may use foot/feet for repetitive movement as in operating foot controls:
   ☐Yes ☐No
4. Patient is able to:

	Frequently	Occasionally	Not At All
a. Bend	☐	☐	☐
b. Squat	☐	☐	☐
c. Climb	☐	☐	☐
d. Twist	☐	☐	☐
e. Reach	☐	☐	☐

Other Instructions and/or Limitations Including Prescribed Medications:

These restrictions are in effect until _____ (date) or until patient is re-evaluated on _____ (date)

3. ☐ **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:

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.

WEST BEND®

THE SILVER LINING®

WB-2593 (4-13)

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?

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.

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 / / Time Reported	Reported to Whom?	

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? ☐ yes ☐ no

Employee was assisting with the operations?

4. Did injury occur because of: Failure to follow safety rules ☐

Failure to use safety device ☐ Other ☐

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 ☐ No ☐

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 ☐	No ☐	_____	_____/_____
Equipment repair/replacement	Yes ☐	No ☐	_____	_____/_____
Reduce Clutter	Yes ☐	No ☐	_____	_____/_____
Improve design/construction	Yes ☐	No ☐	_____	_____/_____
Workstation Modification	Yes ☐	No ☐	_____	_____/_____
Discipline of person(s) involved	Yes ☐	No ☐	_____	_____/_____
Other				

Signature of Person Completing Investigation: _____

Date: _____

Employee Accident Report

Name: _____ Accident Location: _____

Date of Injury: _____Time: _____a.m.☐ p.m.☐ Date Reported: _____

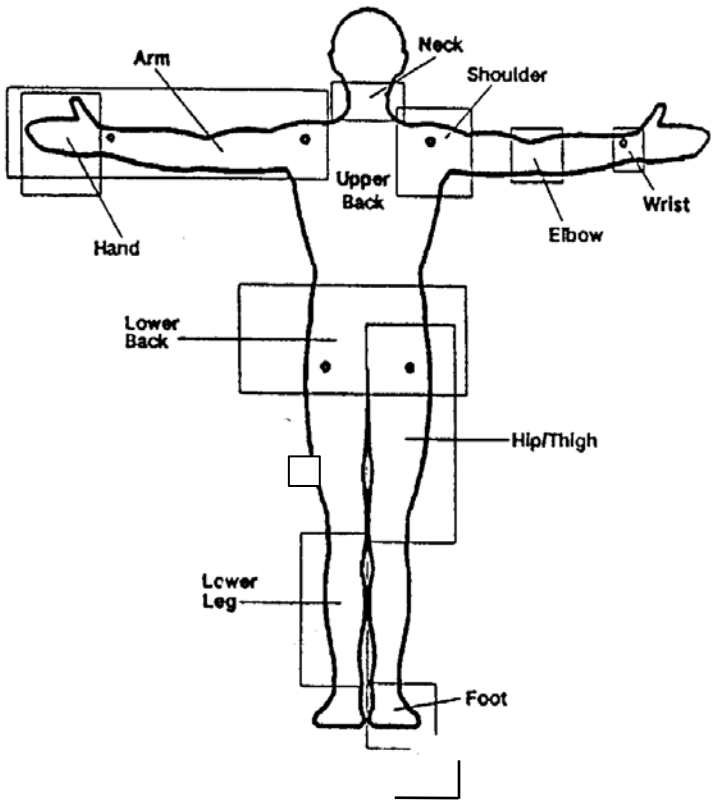
Witnesses:_____

Accident Description: _____

_____

_____

_____

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