



Accident Reporting Procedures

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

Submit all MEDICAL BILLS to:

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

PRESCRIPTION PROCEDURES

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

SUBMIT CLAIMS TO OCCUSURE:

FAX: (615) 377-4735 OR 877-622-7871

E-Mail: janderson@occusure.com

AFTER HOURS EMERGENCY PHONE:

(615) 414-5569

If you need immediate assistance for a serious injury or death that occurs after normal business hours.



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

Fax

To: Claims Adjustor,

From:

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

Pages:

Phone: 615-373-0500

Date:

Re: Occupational Injury

Claim Type:

**No Medical Treatment
(Report Only)**

Med Only Claim

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

Employers First Report of Work Injury or Illness

Employees Choice of Physician Form (if required)

HIPAA Compliant Authorization for Release of Protected Health Information

Any Medical Notes received from medical provider and Work Status Form

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

**C20
ILLNESS**

EMPLOYER'S FIRST REPORT OF WORK INJURY OR

CLAIMS ADM/CARRIER	JURISDICTION CLAIM # (STATE FILE #)		CLAIM TYPE CODE MED ONLY INDEMNITY BECAME LOST TIME BECAME MED ONLY NOTIFY ONLY TRANSFER		<p>The use of this form is required under the provisions of the Tennessee Workers' Compensation Law and must be completed and filed with your insurance carrier immediately after notice of injury.</p> <p><i>It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.</i></p> <p>If you have questions, the state now has a benefit review system where a Workers' Compensation Specialist can provide assistance. Call 1-800-332-2667 (TDD).</p>		
	CLAMS ADM CLAIM # (INSURER CLAIM #)		CARRIER FEIN				
	OSHA LOG CASE #		FEIN OF CLMS ADM 20-524-8843				
	NAME OF INSURANCE CARRIER		CLMS ADJ PHONE # 877-622-7870				
	CLAIMS ADMIN FIRM NAME (if different from carrier) OccuSure		CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2 1885 GENERAL GEORGE PATTON DRIVE				
	CLAIMS ADJUSTER NAME		CITY FRANKLIN				
		STATE TN		ZIP 37067			
EMPLOYER	EMPLOYER NAME		EMPLOYER FEIN		SIC CODE	PHONE NUMBER	
	EMPLOYER ADDRESS LINE 1 AND LINE 2				NATURE OF BUSINESS		
	CITY		STATE	ZIP	INSURED REPORT NUMBER	EMPLOYER LOCATION #	
POLICY	INSURED NAME (parent co. if different than employer)		POLICY NUMBER		EFF DATE	EMPLOYMENT STATUS CODE	
			SELF INSURED? YES NO		EXP DATE	FULL TIME/REGULAR PART TIME PIECE WORKER SEASONAL VOLUNTEER APPRENTICE FULL TIME APPRENTICE PART TIME	
EMPLOYEE	EMPLOYEE LAST NAME		PHONE INCL AREA CODE		GENDER		
	FIRST	MI	DEPARTMENT REGULARLY WORKED		MALE FEMALE UNKNOWN		
	ADDRESS LINE 1 & 2				OCCUPATION DESCRIPTION		
	CITY		STATE	ZIP	MARITAL STATUS	MARRIED SEPARATED DIVORCED	NCCI CLASS CODE
	SSN	DATE OF BIRTH	DATE OF HIRE				
WAGE	WAGE \$	PERIOD HOURLY DAILY	WEEKLY BI-WEEKLY MONTHLY	NUMBER OF DAYS WORKED PER WEEK	SALARY CONTINUED IN LIEU OF COMPENSATION YES NO		
					FULL WAGES PAID FOR DATE OF INJURY YES NO		
ACCIDENT / INJURY	DATE OF INJURY		TIME OF INJURY COULD NOT BE DETERMINED		AM PM	TIME EMPLOYEE BEGAN WORK ON INJURY DATE AM PM	
	DATE EMPLOYER NOTIFIED OF INJURY		BODY PART AFFECTED CODE		NATURE OF INJURY CODE	CAUSE OF INJURY CODE	
	DATE CLAIM ADM NOTIFIED OF INJURY		How injury or illness occurred. Describe the incident including what the employee was doing just before, the part of the body affected and how, and object or substance that directly harmed the employee.				
	DATE LAST DAY WORKED						
	DATE DISABILITY BEGAN						
	RETURN TO WORK DATE (IF APPLICABLE)						
	DATE OF DEATH (IF APPLICABLE)		IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP				
	DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? YES NO		WIDOW	FATHER	SISTER	TOTAL # DEPENDENTS	
		MOTHER	DAUGHTER	BROTHER			
			SON	HANDICAPPED CHILD			
ADDRESS WHERE INJURY OCCURRED (if other than employer's premises)					COUNTY OF INJURY		
CITY					STATE	ZIP	
TREATMENT	PHYSICIAN NAME			HOSPITAL OR OFF SITE TREATMENT NAME			
	ADDRESS LINE 1 AND 2			ADDRESS LINE 1 AND 2			
	CITY	STATE	ZIP	CITY	STATE	ZIP	
	INITIAL TREATMENT NO MEDICAL TREATMENT	MINOR BY EMPLOYER MINOR BY CLINIC/HOSPITAL		HOSPITALIZED > 24 HRS EMERGENCY CARE	FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED		
OTHER	DATE PREPARED	PREPARER'S NAME & TITLE		PREPARER'S COMPANY NAME	PHONE NUMBER		

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



MEDICAL WAIVER AND CONSENT

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

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

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

(Name of Medical Provider)

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

Dated: _____, 20____.

Patient

Social Security last four numbers

Witness

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

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

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

TO: _____

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

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

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

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

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

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

EXECUTED this _____ day of _____, 20__.

EMPLOYEE/PATIENT

DATE OF BIRTH:

SOCIAL SECURITY NUMBER

PHYSICIAN'S REPORT OF EMPLOYEE INJURY

TO BE SENT WITH INJURED EMPLOYEE AND GIVEN TO PHYSICIAN

All referrals for testing or to another doctor require authorization. All bills for authorized medical treatment must have corresponding medical notes attached and should be directed to:
OccuSure PO BOX 682829 / FRANKLIN, TN 37068 615-373-0500/ FAX 615-377-4735

TO BE COMPLETED BY EMPLOYER PRIOR TO TREATMENT BY PHYSICIAN:

Employer Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Contact: _____

Name of Injured Employee: _____ Date of Injury: _____

Description of Incident: _____

Body part(s) To Be Treated: _____

Authorized Employers Signature: _____ Date: _____

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

TO BE COMPLETED BY TREATING PHYSICIAN:

Date of First Treatment: _____

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

Diagnosis: _____

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

Treatment Prescribed and Prognosis: _____

Medications/Testing Prescribed: _____

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

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

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

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

May return to work today without restrictions May return to work today with restrictions as indicated below for _____ days

May not return to work until _____ Reason _____

If restrictions are required, please indicate below

- | | |
|--|---|
| <input type="checkbox"/> No standing over _____ hrs. | <input type="checkbox"/> No lifting over _____ lbs |
| <input type="checkbox"/> No overhead reaching | <input type="checkbox"/> No stooping/bending/twisting |
| <input type="checkbox"/> No use using _____ hand/upper extremity | <input type="checkbox"/> No walking over _____ hours |
| <input type="checkbox"/> No climbing | <input type="checkbox"/> No weight bearing _____ foot |
| <input type="checkbox"/> No pushing/pulling over _____ lbs. | <input type="checkbox"/> No operation of machines |
| <input type="checkbox"/> Keep wound clean, dry | <input type="checkbox"/> Other: _____ |

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

Will employee require further medical treatment? ___No ___ Yes, PRN ___ Yes If yes, date of next appt: _____

Expected date of MMI _____ Please explain _____

Signature of Physician: _____

Date: _____