AmTrust North America
An AmTrust Financial Company

Idaho
Worker's Compensation
Claim Kit

AmTrust North America
An AmTrust Financial Company

Table of Contents

AmTrust North America
An AmTrust Financial Company

EASY ONLINE CLAIMS REPORTING INSTRUCTIONS

By logging into AmTrust's web portal, policyholders can access a wide variety of account information including the ability to report injuries online. The following instructions will help get you started.

First Time Portal Access:

1. Go to www.amtrustnorthamerica.com
2. In the upper right corner of the home page, click "LOGIN"
3. In the subsequent AmTrust *Online* drop-down box, click the word "**Register**"
4. On the following screen, enter your policy number, zip code and the security code that appears on that screen and click "**Enter**" at the bottom right of the screen
5. Enter your email address, user name and password to complete the registration process
6. After completing the registration process, go back to www.amtrustnorthamerica.com and log in

Reporting of New Injuries:

1. Go to www.amtrustnorthamerica.com
2. Log in to "AmTrust ***Online***"
3. Click the "**Claims**" icon in the upper middle of your screen to view the screen that lists your policies
4. Click "**View**" next to the policy for which you wish to enter a claim. This brings you to the policy detail screen
5. Click on "**First Reports**" in the upper left corner
6. On the next screen, click "**Add**" to view the "**New First Report of Injury**" screen
7. Click "**Use WebForm**." This brings you to the screen where you will enter all of the detailed information about the injury/injured worker
8. When finished entering all of the data, click "**Submit**" and this report will channel into our intake center to be set up and assigned to a claims adjuster
9. Return to the "**First Reports"** screen and you will see the claim number for the report entered
10. When finished, click on "**Return to Listing**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

AmTrust North America
An AmTrust Financial Company

Helpful Hints:

- "**Time Employee Began Work**" and "**Time of Occurrence**" must be entered in military time
- Enter the hours in the first box and the minutes in the second box
- All dates must be entered as two-digit day, two-digit month and four-digit year, i.e.: XX/XX/XXXX
- For PEOs, in the "**Location Address**" box, please include the PEO client name and address of the applicable PEO client location. If there is a location code/number, specify in the "**Location #**" box
- If during the entry of a claim you must exit the application, first click on "S**ave as Draft**" and you may return to it later by going back into the "**First Reports"** screen and clicking on "**In Progress**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

Thank you for your attention to this matter.

Sincerely,

AmTrust North
America Claims
Department

800 Superior Avenue E • 21st Floor • Cleveland, OH 44114
(p) 866.203.3037 • (f) 800.487.9654 • www.amtrustnorthamerica.com

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General

Employer (Name & Address incl. zip)

Carrier/Administrator Claim Number | Report Purpose Code

Jurisdiction | Jurisdiction Claim No.

Insured Report No.

Employer's Location Address (if different) | Location No.

NAICS Code | Employer FEIN | Phone No.

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)

P.O.BOX 89453
CLEVELAND, OH 44101
888-239-3909

Policy Period

To

☐ Check if self insured

Claims Admin (Name, Address & Phone Number)

Intermountain Claims, Inc.
P.O. Box 4367
Boise, ID 83711
888-239-3909

Carrier FEIN | Policy Number or Self-Insured Number | Administrator FEIN

Agent Name & Code Number

Employee

Legal Name (Last, First, Middle) | Birth Date | Social Security Number | Date Hired | State of Hire

Address (Incl. Zip)

Sex: ☐ Male ☐ Female ☐ Unknown

Marital Status: ☐ Unmarried/ Single/Div. ☐ Married ☐ Separated ☐ Unknown

Occupation/Job Title

Employment Status

Phone

No. of Dependents

NCCI Class Code

Wage Rate $ ☐ Day ☐ Week ☐ Month ☐ Other

Days Worked/WK

Hrs Worked per Day

Full Pay for Date of Injury? ☐ Yes ☐ No

Did Salary Continue? ☐ Yes ☐ No

Occurrence

Time Employee Began Work ☐ AM ☐ PM | Date of Injury or Illness | Time Occurred ☐ AM ☐ PM | Last Work Date | Date Employer Notified | Date Disability Began

Employer Contact Name/Phone Number | Type of Illness/Injury | Part of Body Affected

Did Injury/Illness Exposure Occur on Employer's Premises? ☐ Yes ☐ No | Type of Illness/Injury Code | Part of Body Affected Code

Department or location where accident or illness exposure occurred | All Equipment, Materials, or Chemicals Employee Using upon Occurrence

Specific Activity Employee Engaged in at Time of Occurrence | Work Process the Employee Was Engaged in at Time of Occurrence

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 Returned to Work | If Fatal, Date of Death

Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No

Were they used? ☐ Yes ☐ No

Treatment

Physician/Health Care Provider (Name & Address)

Hospital (Name & Address)

Initial Treatment

- 0 ☐ No Medical Treatment
- 1 ☐ Minor: By Employer
- 2 ☐ Minor Clinic/Hosp
- 3 ☐ Emergency Care
- 4 ☐ Hospitalized – 24 hr.
- 5 ☐ Anticipated Major Med/Lost Time

Other

Signature of Injured Employee, or Signature on File, Date

Witness to Accident (Name & Phone Number)

Date Administrator Notified | Date Prepared | Preparer's Name & Title | Preparer's Phone Number

Filing this report is not an admission of liability. This report shall not be evidence of any fact stated herein in any proceeding in respect of the injury, illness or death on account of which this report is made. Idaho Industrial Commission, P.O. Box 83720, Boise, ID 83720-0041 IC Form IA-1 (08/2013)

Instructions for Submitting a Workers' Compensation
First Report of Injury or Illness (IC1A-1)

If you are an insured employer:

Effective November 4, 2017, employers or a representative must submit the First Report of Injury (FROI) in electronic form in accordance with the IAIABC EDI Release 3.0 and the Commission's EDI Guides and Tables. Employers are required to notify their workers' compensation claims administrator for proper filing. It is no longer necessary to forward a paper copy to the Industrial Commission.

If you are an injured worker / injured worker's legal counsel / non-insured employer:

Individual injured workers, injured workers' legal counsel, and employers that are not insured are not required to comply with IAIABC EDI requirements for filing of the FROI. For these individuals, the following instructions apply:

1. The form should be filled out by the uninsured employer or a representative; however, the injured employee may fill out the form if necessary.
2. Fill out non-shaded areas as completely as possible.
3. Distribute copies of the completed form as follows:

    a. The original to:

        Idaho Industrial Commission
        PO Box 83720
        Boise, ID 83720-0041

        The .pdf can be emailed to the Commission; however, you must fill out the form, save it under a different name, and then send as an email attachment to froi@iic.idaho.gov.

    b. One copy retained for the employer's/employee's files.

4. The Idaho Industrial Commission will be happy to answer your questions or provide you with helpful brochures on Facts for Injured Workers and Guides for Employers. To obtain this service, please contact the Idaho Industrial Commission at (208) 334-6000; or you may access many of these brochures at www.iic.idaho.gov .

OPTUM®

AmTrust North America
An AmTrust Financial Company

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

AmTrust North America
An AmTrust Financial Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-109-FFWG

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
PORTADORA — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL — FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-109-FFWG

RETURN-TO-WORK; A **GREAT** IDEA

We at the AmTrust Group, are convinced that an employer who provides light, or restricted work for injured employees, enjoys numerous benefits. This is not just an opinion, it's something we see day in and day out. Consider:

- Unless an injured worker returns to the workplace within 60 days, chances of him/her ever returning drop dramatically. (resulting in a very expensive permanent disability situation.)
- After 6 months away from the workplace, only 50% chance of return.
- After 12 months, only a 10% chance of return.

Some Return-to Work Benefits Include:

- "Test" of malingering potential. Injured employees who refuse light duty are more prone to being malingerers.
- Opportunity for employer to demonstrate true concern for workers' well-being.
- Promotion of rehabilitation and recovery.
- Lower medical and rehabilitation costs.
- Productivity.
- Morale improvement for the injured worker.
- Ability for the employer to monitor the injured employee's recovery progress.
- Decrease of WC claims costs, with resultant downstream WC premium savings.

(Notice we're not just talking about 'feel-good' issues, but also hard dollars !)

Some common misconceptions (and truths) about Return-to-Work / Light Duty:

Misconception: *We've already got too many "programs" around here, and don't need any more paper*.

Truth: While it is true a written, planned program works best, in many cases a Light Duty "program" can be nothing more than a management understanding of the benefits and principles of Return-to-Work, how it works, and the commitment to "just do it", when light-duty recommendations are made by WC physicians.

Misconception: *It will get me into an Americans With Disabilities (ADA) "situation".*

Truth: Light-duty and ADA "reasonable accommodation" are two entirely separate issues. Generally, light duty is a temporary assignment, for a relatively short period. ADA accommodations are made for serious, permanent disabilities that impair major life activities.

Misconception*: I'll have to devise a whole new job each time an employee needs light duty.*

Truth: The vast majority of light-duty restrictions require accommodating only one or two factors, such as "no lifting over 10 pounds", or the like. In many cases, if you break the jobs down into individual **tasks**, you'll see that only one or two tasks within the employee's normal job are affected, and can be handled in some other way.

Misconception: *Once an employee gets into a "cushy" light-duty job, s/he'll never leave it, and I'll be stuck with it.*

Truth: Light duty is always defined by, and monitored by the attending physician. An employee on light duty is periodically monitored by the physician for improvement, and is released for full-duty as soon as medically indicated.

Misconception: *We're a union company. Our union won't allow us to pay lower rates, or move employees between classifications, or between bargaining groups.*

Truth: Any Local that objects to a Return-to-Work program should be referred to its national body for guidance. Return to Work is universally recognized as a very positive influence on an injured worker (as well as benefiting the employer). Labor unions, whose major purpose for existence is the benefit of the workers they represent, should not only "tolerate" Return-to-Work programs, but enthusiastically promote, and assist in such programs' implementation and operation. It is strongly suggested that management approach labor representatives to solicit their input, and assistance in making Return to Work a positive force in your workplace.

Misconception: *I might be willing to place a worker in a light-duty position, but I can't afford pay them their full pay, for the decreased productivity.*

Truth: Talk to your WC insuror's claims professional. In many cases, states' WC plans provide for "make-up" pay to replace some, or all of the injured employees' decreased earnings. The goal of getting them back to the workplace, and doing some productive work is that important!

TO THE EMPLOYER: THIS NOTICE MUST BE POSTED IN A CONSPICUOUS PLACE UPON YOUR PREMISES.

NOTICE

REGARDING WORKERS' COMPENSATION INSURANCE

ALL WORKERS EMPLOYED BY THE UNDERSIGNED ARE HEREBY NOTIFIED THAT THE EMPLOYER HAS COMPLIED WITH THE LAW AS TO SECURING THE PAYMENT OF COMPENSATION TO EMPLOYEES AND THEIR DEPENDENTS, IN ACCORDANCE WITH THE PROVISIONS OF THE WORKERS' COMPENSATION LAW.

_____
Employer

_____
Date

By

_____
Employer's Authorized Agent

An employee receiving an injury by accident must immediately notify his/her supervisor, superintendent, or the undersigned, who will provide medical attendance.

Claim for compensation must be made in writing and given to the employer. Forms for giving notice of injury and making claim for compensation will be furnished by the employer, by the surety, P.O. Box 89453
Cleveland, OH 44101

or upon application, by the Industrial Commission in Boise, Idaho.

AL EMPLEADOR: ESTE AVISO DEBE COLOCARSE EN UN LUGAR VISIBLE DE SUS INSTALACIONES.

NOTAR

CON RESPECTO AL SEGURO DE COMPENSACIÓN PARA TRABAJADORES

SE NOTIFICA A TODOS LOS TRABAJADORES EMPLEADOS POR EL ABAJO FIRMANTE QUE EL EMPLEADOR HA CUMPLIDO CON LA LEY EN CUANTO A LA OBTENCIÓN DE EL PAGO DE COMPENSACIÓN PARA EMPLEADOS Y SU DEPENDIENTES EN CONFORMIDAD CON EL PROVISIONESDE EL LEY DE COMPENSACIÓN PARA TRABAJADORES.

_____
Empleador

_____
Fecha

Por

_____
Agente Autorizado del Empleador

Un empleado que recibe una lesión por accidente debe notificar inmediatamente a su supervisor, superintendente o al abajo firmante, quien le brindará asistencia médica.

La reclamación de indemnización debe hacerse por escrito y entregarse al empleador. Los formularios para notificar la lesión y reclamar una indemnización serán proporcionados por el empleador, por el fiador,

P.O. Box 89453
Cleveland, OH 44101

o a solicitud de la Comisión Industrial de Boise, Idaho.

PETITION FOR CHANGE OF PHYSICIAN

Employee Name and Address: Telephone Number: Social Security Number:	Employer Name and Address:
Current Physician and Address:	Surety Name and Address (if known):
Requested Physician and Address:	Additional Information or Documentation Attached (Circle One): No ☐ Yes ☐

Date of Injury/Disease: _____

Medical Treatment to Date: _____

_____

_____

Reason for Change: _____

_____

Hearing Date/Time Availability Next 30 Days: _____

If the employer/surety responds that no further medical treatment is reasonable or necessary, then you must instead pursue your claim through the complaint process. You will be notified by mail if this is the case, and no hearing will be set.

Date: _____ Signature: _____

Typed/Printed Name: _____

ORIGINAL TO EMPLOYER OR SURETY

Copy to Idaho Industrial Commission, PO Box 83720, Boise, ID 83720-0041, or fax to 208-332-7558.

CERTIFICATE OF SERVICE

I hereby certify that on the _____ day of _____, 20___, I caused to be served the Original Petition for Change of Physician upon either the following Employer or its Surety:

EMPLOYER'S NAME AND ADDRESS		SURETY'S NAME AND ADDRESS
_____	OR	_____
_____		_____
_____		_____
via:		via:
( ) Personal Service of Process		( ) Personal Service of Process
( ) Regular U. S. Mail		( ) Regular U.S. Mail

I also hereby certify that on the _____ day of _____, 20___, I caused to be served a true and correct copy of the foregoing Petition for Change of Physician upon:

Idaho Industrial Commission
700 South Clearwater Lane
Post Office Box 83720
Boise, Idaho 83720-0041

via: ( ) Personal Service of Process

( ) Regular U. S. Mail

( ) Faxed to 208-332-7558

_____
Signature

_____
Typed or Printed Name

RESPONSE TO PETITION FOR CHANGE OF PHYSICIAN

Employer Name and Address: **Telephone Number:**	**Surety Name and Address:** **Telephone Number:**
Employee Name and Address:	**Additional Documentation to Support Decision (circle one):** **No ☐ Yes ☐**

Response to petition (circle one): ◯Approved ◯ Denied

Reasons for Denial: ☐ Further medical treatment is not reasonable or necessary._____

☐Other (Please explain)

Hearing Dates/Times Availability Next 14 Days:

Date: **Signature:**

Typed/Printed Name:

Title:

Original to Idaho Industrial Commission, PO Box 83720, Boise, ID 83720-0041, or faxed to the Commission at 208-332-7558.

Copy to Employee.

CERTIFICATE OF SERVICE

I hereby certify that on the _____ day of _____, 20____, I caused to be served the Original Response to Petition for Change of Physician upon:

Idaho Industrial Commission
Post Office Box 83720
Boise, Idaho 83720-0041

via: ◯ Personal Service of Process

◯ Regular U. S. Mail

◯ Faxed to 208-332-7558

I also hereby certify that on the _____ day of _____, 20___, I caused to be served a true and correct copy of the foregoing Response to Petition for Change of Physician upon:

CLAIMANT'S NAME AND ADDRESS

via: ◯ Personal Service of Process

◯ Regular U. S. Mail

◯ Faxed to 208-332-7558

_____
Signature

_____
Print or Type Name

REIMBURSEMENT FOR HEALTH CARE TRAVEL EXPENSES
PURSUANT TO SECTION 72-432(1), IDAHO CODE

Name of Injured Worker _____ Carrier Claim # _____

SSN _____Address _____

Phone # _____ Date of Injury/Manifestation_____

Date	Medical Provider	Provider Address and City	Round Trip Miles
/ /			
/ /			
/ /			
/ /			
/ /			
		Less 15 Miles for Each Round Trip	
		Total Allowable Miles*	
		Current Mileage Rate**	$ /mile
		Total Reimbursement Request	$

1. Use this form when claiming reimbursement for travel expenses incurred while pursuing reasonable or necessitated diagnosis, treatment, or care of an industrial injury or occupational disease.

2. *****Only mileage in excess of fifteen (15) miles for any given round trip is reimbursable. However, you should report the total mileage for each round trip. You are expected to take the shortest practical route of travel.

3. ******Reimbursement shall be made at the mileage rate allowed by the State Board of Examiners for state employees. The current rate for this mileage is available through your insurance company, by contacting the Idaho Industrial Commission, or by visiting http://www.sco.idaho.gov.

4. While prompt submittal of your claim for travel reimbursement is important, you should not submit requests for reimbursement more frequently than once every thirty (30) days.

5. YOU MUST ATTACH TO THIS FORM A COPY OF A BILL OR RECEIPT SHOWING THAT EACH VISIT OCCURRED

STATEMENT OF WAGES/SALARY

IMPORTANT: PLEASE COMPLETE ALL INFORMATION REQUESTED

Employee: Employer: Claim Number:
Social Security Number: Date of Hire: Position/Job Title

EMPLOYMENT TYPE: Full Time____Part Time____Seasonal____Temp_____
If Temporary or Seasonal worker, last day of season or job end date _____
WAGE TYPE: Hourly____Salary____Commission____
WAGE INFORMATION:
$_____ per hour ; Monthly Wage $_____ ; Does monthly wage include commission ____Yes ___No
Hours per Week _____ ; Overtime Rate $_____per hour ; Overtime Hours Regularly Worked per week ____
Tips reported: $_____ per week

If employees' compensation package includes an allowance for any of the following, please indicate the actual or estimated value:
Meals: $_____per week Auto: $_____ Rent/Lodging: $_____per week Bonus $_____ per __wk__mth__yr

PLEASE COMPLETE THE BELOW FOR THE PERIOD _____ TO _____

WK	Pay Rate	Hrs Worked	Begin Date	End Date	Gross Salary	WK	Pay Rate	Hrs Worked	Begin Date	End Date	Gross Salary
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
15						41					
16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					