



AmTrust North America
An AmTrust Financial Company

Oklahoma Worker's Compensation Claim Kit



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Workers' Compensation Claim Reporting Information

24/7 Toll Free Claim Reporting for All States



(888)239-3909



WorkersCompClaimReport@AmTrustgroup.com



www.amtrustfinancial.com

Information Required for All Claims Reported



1. Name of the insured and policy number
2. Name, social security number and contact information of injured worker
3. Date, time and place of accident
4. Description of accident or incident
5. Name, phone, and/or email of person making the report
6. Any information on the injured workers lost time

Early claim reporting is essential to a better claim outcome. Don't delay reporting if you do not have all the details.

How do I help my injured worker find a doctor?



- We offer an online physician search for all states, www.talispoint.com/amtrust/external
- For California, www-lv.talispoint.com/amtrust/campn
- For CO, GA, PA & TN, please refer to the panel provided by AmTrust via mail or email

How does my injured employee receive prescription medications related to the accident/injury?



- Refer to the claims kit for your state at www.talispoint.com/amtrust/external for a First Fill card for your injured employee to use at the pharmacy to cover the cost of approved medication.

Timely Reporting

When a work-related injury occurs, it is important to act immediately. Timely reporting of a new claim helps to provide a smooth and successful claim process for both you and your injured worker.



We're Here To Help

After your claim has been filed, we may be in touch to obtain additional information. Our goal is to offer a smooth and hassle-free experience – from your first contact to the claims conclusion. Feel free to also call us with any questions. We're here to help.



Relax And Stay Positive

You have the assurance of our knowledge, expertise, and understanding of the claim process. We're with you all the way.

877.528.7878 | www.amtrustfinancial.com

This material is for informational purposes only and is not legal or business advice. Neither AmTrust Financial Services, Inc. nor any of its subsidiaries or affiliates represents or warrants that the information contained herein is appropriate or suitable for any specific business or legal purpose. Readers seeking resolution of specific questions should consult their business and/or legal advisors. Coverages may vary by location. Contact your local RSM for more information.



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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.



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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 **“Save 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

Workers Compensation Posting Requirements

Thank you for placing your Workers' Compensation Coverage with AmTrust.



CC-Form-1A Oklahoma Workers' Compensation Notice & Instruction to Employers & Employees

- ✧ Post at place of employment, in a sufficient number of places on the premises to assure that the notice will reasonably be seen by all employees.
- ✧ Employees that may not reasonably be expected to see a posted notice must receive notice of the posting in writing.
- ✧ The notice(s) shall contain the name and address of the carrier, as well as the expiration date.

To complete the form, please enter the name of your designated insurance carrier, your policy expiration date as well as a signature of a company representative. For your convenience, our contact information has been completed on the poster.

(Oklahoma Statutes § 85-43(D))



You may send an email to clientservices@amtrustgroup.com with any Claims Kit related questions. Please make sure to include your policy number along with your request.



I have a question about a claim or injured worker, who do I contact?

Customer Service can direct you to the appropriate person. Please contact them at 888-239-3909.

All employees of this employer who are entitled to benefits of the Administrative Workers' Compensation Act are hereby notified that this employer has complied with all rules of the Workers' Compensation Commission and that this employer has secured payment of compensation for all employees and their dependents in accordance with the Act. All employees are further notified this employer will furnish first aid, medical, surgical, hospital, optometric, podiatric, chiropractic and nursing services, medicine, crutches and other apparatus as may be reasonably necessary in connection with the injury received by the employee, as well as payments of compensation to any injured employee or the employee's dependents as provided in the Act.

Any employee who has suffered a compensable injury covered by the Administrative Workers' Compensation Act is entitled to vocational rehabilitation services, including retraining and job placement, if, as a result of the injury, the employee is unable to perform work for which the person has previous training or experience.

The Oklahoma Workers' Compensation Commission has a Counselor Division to provide information to injured workers, employers, and other interested persons.

Mediation is available to help resolve certain workers' compensation disputes. For information, call the Counselor Division at 405-522-5308 or In-State Toll Free 855-291-3612.



Signature of Employer _____
PO Box 89404
Cleveland, OH 44101

Insurer Name and Address _____

Date of Expiration of Insurance Policy (Not applicable to employers authorized to self-insure.) _____

Employee's Responsibilities In Case of Work Related Injury

If accidentally injured or affected by cumulative trauma or an occupational disease arising out of and in the course of employment, however slight, the employee should notify the employer immediately. If this employer is a partnership, notice shall be given to any partner. If this employer is a corporation, notice shall be given to any agent or officer of the corporation upon whom legal process may be served. Notice shall also be given to the person in charge of business at the location of operations where the injury occurred. Unless oral or written notice is given to the employer within thirty (30) days, the claim for compensation may be forever barred.

The employee may file a claim for compensation with the **WORKERS' COMPENSATION COMMISSION** for an accidental injury, death, cumulative trauma or occupational disease or illness occurring **ON OR AFTER** February 1, 2014. Forms to file a compensation claim should be furnished by this employer and also are available from the Workers' Compensation Commission. The forms are posted on the Commission's website, www.wcc.ok.gov.

A claim for compensation must be filed with the Commission within the time specified by law, or be forever barred. Based on law effective May 28, 2019, a claim for compensation for any accidental injury must be filed with the Commission within one (1) year of the date of injury or, if the employee has received benefits under Title 85A for the injury, six (6) months from the date of the last issuance of such benefits; a death claim must be filed within two (2) years of the date of death; a claim for compensation for occupational disease or illness must be filed within two (2) years of the last injurious exposure; and a claim for compensation for cumulative trauma must be filed within one (1) year of the date of injury.

Claims for compensation for accidental injury, death, cumulative trauma or occupational disease or illness occurring BEFORE February 1, 2014 may be filed with the WORKERS' COMPENSATION COURT OF EXISTING CLAIMS and are subject to different notice of injury requirements and claims filing deadlines than those for accidental injury, death, cumulative trauma or occupational disease or illness occurring on or after February 1, 2014. Failure to comply with applicable notice requirements and deadlines may operate to forever bar the claim. Contact the WORKERS' COMPENSATION COURT OF EXISTING CLAIMS for additional information.

Employer's Responsibilities

The employer must provide employees with immediate first aid, medical, surgical, hospital, optometric, podiatric, chiropractic, and nursing services, medicine, crutches and other apparatus as may be reasonably necessary in connection with the injury received by the employee. This applies to care for all injuries and illnesses arising out of and in the course of employment, regardless of their character. Within ten (10) days after the date of receipt of notice or knowledge of death or injury that results in the loss of time beyond the shift or medical attention away from the work site, the employer or the employer's representative **MUST** send a report thereof to the Workers' Compensation Commission via Electronic Data Interchange as specified in Commission rules.

No agreement by any employee to pay any portion of the premium paid by the employer to a carrier or a benefit fund or department maintained by the employer for the purpose of providing compensation or medical services and supplies as required by the workers' compensation laws, shall be valid. Any employer who makes a deduction for such purposes from the pay of any employee entitled to benefits under the workers' compensation laws shall be guilty of a misdemeanor.

No agreement by any employee to waive workers' compensation rights and benefits shall be valid.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

**Workers' Compensation Commission
1915 North Stiles Avenue
Oklahoma City, Oklahoma 73105-4918**

**Tele. 405-522-5308 (OKC) · 918-295-3732 (TU) · In-State Toll Free 855-291-3612
Web Site · www.wcc.ok.gov**

Aviso e Instrucción de Compensación de Trabajadores de Oklahoma para Empresarios y Trabajadores

Se notifica por la presente a todos los empleados de esta empresa que tengan derecho a los beneficios de la Ley de Compensación para Trabajadores Administrativos que este empleador ha cumplido con todas las reglas de la Comisión de Compensación de Trabajadores, y que este empleador ha asegurado el pago de compensación a todos los empleados y sus dependientes en conformidad con la ley. Asimismo, se notifica a todos los empleados que este empleador proporcionará primeros auxilios, servicios médicos, quirúrgicos, hospitalarios, de optometría, podología, y enfermería, medicina, muletas y otros aparatos que sean razonablemente necesarios en relación con la lesión sufrida por el trabajador, así como los pagos de compensación a cualquier empleado lesionado o sus dependientes conforme a lo dispuesto por la ley.

Cualquier empleado que haya sufrido una lesión indemnizable amparado por la Ley de Compensación para Trabajadores Administrativos tiene derecho a los servicios de rehabilitación vocacional, esto incluye la re-capacitación e inserción laboral si el empleado ya no pudiese realizar el trabajo para el cual tuviese formación o experiencia previa como consecuencia de la lesión.

La Comisión de Compensación de Trabajadores de Oklahoma cuenta con una División de Asesoría para proporcionar información a los trabajadores lesionados, empleadores y otras personas interesadas.

Existe la posibilidad de mediación para ayudar a resolver disputas de compensación para ciertos trabajadores. Para obtener más información, llame a la División de Consejería al 405-522-5308 o al número gratuito (dentro del estado) 855-291-3612.



Firma del Empleador

PO Box 89404

Cleveland, OH 44101

Nombre y Dirección del Asegurador

Fecha de Vencimiento de la Póliza de Seguro (No aplicable a los empleadores autorizados para auto-asegurarse.)

Responsabilidades del empleado en caso de sufrir una lesión relacionada trabajo

De resultar dañado o afectado por trauma acumulativo o una enfermedad profesional que surja del empleo y en el transcurso de su desempeño, por leve que sea, el empleado debe notificar al empleador inmediatamente. Si este empleador es una sociedad, se debe notificar a cualquier socio. Si este empleador es una corporación, la notificación se hará a cualquier agente o funcionario de la corporación autorizado a recibir tal notificación. Se notificará también a la persona a cargo de los negocios en el lugar de operaciones donde se haya producido la lesión. De no haber notificado verbalmente o por escrito al empleador dentro de los treinta (30) días, el reclamo de indemnización puede prescribir de forma definitiva.

El empleado puede presentar un reclamo de indemnización ante la **COMISIÓN DE COMPENSACIÓN DE TRABAJADORES** por una lesión accidental, muerte, trauma acumulativo o enfermedad profesional o enfermedad accidental que ocurra **EL 1 de febrero de 2014, O DESPUÉS** de esa fecha. Este empleador debe suministrar los formularios para presentar un reclamo de compensación, y también se encuentran disponibles en la Comisión de Compensación de Trabajadores. Los formularios se encuentran publicados en el sitio web de la Comisión, www.wcc.ok.gov.

El reclamo de compensación debe ser presentado ante la Comisión en el plazo fijado por la ley, o prescribirá para siempre. En virtud con la Ley vigente al partir del 28 de mayo de 2019, los reclamos de indemnización por cualquier lesión accidental se deben presentarse ante la Comisión dentro de un (1) año transcurrido a partir de la fecha de la lesión; o, si el empleado ha recibido beneficios bajo el Título 85A por la lesión, seis (6) meses desde la fecha de la última emisión de dichos beneficios; un reclamo de muerte debe presentarse dentro de los dos (2) años a partir de la fecha de la muerte; los reclamos de indemnización por males o enfermedades profesionales se deben presentar dentro de los dos (2) años transcurridos a partir de la última exposición perjudicial; y los reclamos de indemnización por trauma acumulativo se deben presentar dentro de un (1) año transcurrido a partir de la fecha de la lesión. Se prohíben los reclamos de indemnización adicional a menos que sean presentados dentro de un (1) año transcurrido a partir del último pago de compensación por discapacidad o dos (2) años desde la fecha de la lesión, el período que sea mayor.

Los reclamos de indemnización por lesiones, muerte, trauma acumulativo o males o enfermedades profesional accidentales que ocurrieran ANTES del 1 de febrero de 2014 se pueden presentar ante el TRIBUNAL DE RECLAMOS EXISTENTES DE COMPENSACIÓN AL TRABAJADOR y estarán sujetos a diferentes requisitos de notificación de la lesión y distintos plazos para presentar reclamos a los requeridos para los correspondientes a lesiones accidentales, muerte, trauma acumulativo o males o enfermedades profesionales que ocurrieran a partir del 1 de febrero de 2014. El incumplimiento de los requisitos y los plazos de notificación aplicables puede resultar en la prescripción definitiva del reclamo. Póngase en contacto con el Tribunal de Reclamos Existentes de Compensación al Trabajador para obtener información adicional.

Responsabilidades del Empleador

El empleador debe proporcionar a los empleados primeros auxilios, servicios médicos, quirúrgicos, hospitalarios, de optometría, podología, quiropráctica, así como servicios de enfermería, medicina, muletas y otros aparatos que sean razonablemente necesarios en relación con la lesión sufrida por el empleado. Esto es aplicable al cuidado de todas las lesiones y enfermedades que surjan del empleo y el transcurso de su desempeño, independientemente de su carácter. El empleador o su representante, **DEBERÁ** enviar, dentro de los diez (10) días a partir de la fecha de recepción de la notificación o el conocimiento de la muerte o lesión que resulte en pérdida de tiempo más allá del turno o atención médica fuera del lugar de trabajo del empleado lesionado, un informe sobre esto a la Comisión de Compensación de Trabajadores, a través del Intercambio Electrónico de Datos, como se especifica en las reglas de la Comisión.

Se invalidará cualquier acuerdo hecho por un empleado para pagar cualquier porción de la prima pagada por el empleador a un operador, fondo de prestaciones o departamento mantenido por el empleador con el fin de indemnizar o proveer servicios y suministros médicos, tal como lo requieren las leyes de compensación de los trabajadores. Cualquier empleador que realice una deducción del pago de cualquier empleado con derecho a prestaciones en virtud de las leyes de compensación de los trabajadores para tales propósitos será culpable de un delito menor.

Se invalidará cualquier acuerdo hecho por un empleado para renunciar a los derechos y beneficios de compensación del trabajador.

**Toda persona que cometa fraude de compensación del trabajador, será culpable, de ser condenada,
de un delito grave punible con pena de prisión, una multa o ambas.**

**Comisión de Compensación de Trabajadores
1915 North Stiles Avenue Ste 231
Oklahoma City, Oklahoma 73105-4918**

**Tel. 405-522-5308 (OKC) · 918-295-3732 (TU) · Línea gratuita (dentro del estado) 855-291-3612
Sitio Web · www.wcc.ok.gov**

CC-FORM-2

Applicable to Injuries /Deaths Occurring On or After 2/1/14

Send original to Workers' Compensation Commission and
1 copy to Insurance Carrier

Please type or print. Enter all dates in MM/DD/YY format.

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE STE 231
OKLAHOMA CITY, OK 73105

EMPLOYER'S FIRST NOTICE OF INJURY

THIS SPACE FOR COMMISSION USE ONLY

Full Name of Employee - LAST, FIRST, MIDDLE		Employee Email Address	
Complete Address	City	State	Zip
Telephone Number	Employee's Social Security Number (LAST 5 DIGITS ONLY) XXX-X		
Date of Birth	Sex	Length of Employment: Years ____ Months ____ Date of Hire: _____	
Average Weekly Wage	Occupation (job description)		Was employment agreement made in Oklahoma? YES <input type="checkbox"/> NO <input type="checkbox"/>

NOTE: Mediation is available to help resolve certain workers' compensation disputes. For information, call (405) 522-5308 or In-State Toll Free (855) 291-3612.

Date of accident or last exposure	Time of accident or exposure o'clock AM <input type="checkbox"/> PM <input type="checkbox"/>	Date Employer Notified	Time workday began o'clock AM <input type="checkbox"/> PM <input type="checkbox"/>
Last date employee worked	Has employee returned to work? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, on what date ? _____	Did the employee die? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, on what date ? _____	
OSHA Log Case #	Place of Accident or Occurrence City: _____ County: _____ State: _____		
Injury Resulted from: Single Incident <input type="checkbox"/> Cumulative Trauma <input type="checkbox"/> Occupational Disease <input type="checkbox"/>			
Nature of Injury or Illness		Does employee participate in a certified workplace medical plan: YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, name of CWMP: _____	
Describe activities when injury occurred with details of how event occurred. Include object or substance which directly injured the employee.			
Identify part(s) of body involved in injury or illness			
Full Name and address of Treating Physician (please be complete)			
Employer's Insurance Carrier or Own Risk Group		Policy/Self-Insured Number _____	
Name Address PO Box 89404	C/O AmTrust North America Phone 888-239-3909 City Cleveland	Policy Period: From _____ To _____ State OH	Zip 44101
Employer's Name and Complete Address		Federal ID#	Phone #
Address		City	State
Type of business (Example: manufacturing, food service, construction)		NAICS Number	
Type of Ownership: Private <input type="checkbox"/>	State Government <input type="checkbox"/>	County Government <input type="checkbox"/>	Local Government <input type="checkbox"/>

Administrative Workers' Compensation Act, 85A O.S., §6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment ... shall be guilty of a felony."

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

The undersigned hereby declares under PENALTY OF PERJURY that they have examined this notice and all statements contained herein are true, correct and complete, to the best of their knowledge. The undersigned certifies this CC-Form 2 was sent to the Workers' Compensation Commission and a copy thereof to the employer's insurer on the date noted below:

Signed _____
Signature of Preparer

By _____
Name and Title of Preparer (Please Print)

Telephone Number _____
Area Code and Number

Date _____

A CC-Form 2 must be sent to the Workers' Compensation Commission and to the employer's workers' compensation insurance carrier within 10 days after the date of receipt of notice or knowledge of death or injury that results in the loss of time beyond the shift or requires medical attention away from the work site.

PROVIDING THIS FORM TO THE COMMISSION IS NOT EVIDENCE OF ANY FACT STATED IN THE REPORT IN ANY PROCEEDING WITH RESPECT TO THE INJURY OR DEATH ON ACCOUNT OF WHICH THE REPORT IS MADE.



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

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

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.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."

tmesys®

IMP14-1614-109-FFWG

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

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

	<u>NDC</u>		<u>Envoy</u>
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.

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 insurer'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!

STATEMENT OF WAGES/SALARY

IMPORTANT: PLEASE COMPLETE ALL INFORMATION REQUESTED

Employee:
Social Security Number:

Employer:
Date of Hire:

Claim Number:
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					

CC-FORM-17

WORKERS' COMPENSATION COMMISSION

Send original to: Tulsa Office
Workers' Compensation Commission
Attention: Health Services Division

201 West 5th Street
Tulsa, Oklahoma 74103

THIS SPACE FOR COMMISSION USE ONLY

PART I. Physicians providing treatment under the workers' compensation laws of this state or applying to serve as a Workers' Compensation Commission certified Independent Medical Examiner **MUST** complete Part I of this form. **FAILURE TO DO SO IS GROUNDS FOR DISQUALIFICATION OF THE PHYSICIAN FROM PROVIDING TREATMENT UNDER THE WORKERS' COMPENSATION LAWS OF THIS STATE.** Any change in information must be reported to the Commission as soon as practicable after such change by filing another CC-Form-17 marked "AMENDED". All reported information must be updated annually.

PART II. If a physician or an entity in which the physician has a financial interest, other than an ownership interest of less than 5% in a publically traded company, provides implantable devices, that relationship shall be disclosed to the patient, employer, insurance company, third party administrator, certified workplace medical plan, case manager, and legal counsel for the worker and employer/carrier. The disclosure may be made directly to those persons OR by completing Part II of this form.

ALL INFORMATION SUBMITTED TO THE COMMISSION MAY BE CONSIDERED A PUBLIC RECORD UNDER STATE LAW. Direct questions to the Commission's Health Services Division, (405) 522-3222 or In-State-Toll Free (855) 291-3612.

PHYSICIAN DISCLOSURE STATEMENT

(Please type or print)

Physician Information	Physician Name:	Professional License #:
	Address:	
	City:	State: Zip:

PART I. Disclosure Of Ownership Or Interests In Entities Other Than The Physician's Primary Place of Business

If you are a physician providing treatment under the workers' compensation laws of this state or applying as a Workers' Compensation Commission certified Independent Medical Examiner, you must disclose any ownership or interest in any pharmacy, health care facility, business or diagnostic center that is not the physician's primary place of business. This includes, but is not limited to, disclosure of any leasing agreement between the physician and entity. (Attach supplemental pages as necessary. If you have no disclosures, state "NONE".)

Name of Entity:	Employee Leasing Arrangement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Address:		
City:	State:	Zip:

Name of Entity:	Employee Leasing Arrangement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Address:		
City:	State:	Zip:

PART II. Disclosure Regarding Implantable Devices

If a physician or an entity in which the physician has a financial interest, other than an ownership interest of less than 5% in a publically traded company, provides implantable devices, that relationship shall be disclosed to the patient, employer, insurance company, third party administrator, certified workplace medical plan, case manager, and legal counsel for the worker and employer/carrier. The disclosure may be made directly to those persons OR by completing Part II of this CC-Form-17. (Attach supplemental pages as necessary.)

Physician Provides Implantable Devices?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physician Has Financial Interest, Other Than Ownership Interest of Less Than 5% In A Publically Traded Company, That Provides Implantable Devices? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide name and address of entity below.)	
Name of Entity:	
Address:	
City:	State: Zip:

Physician Provides Implantable Devices?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physician Has Financial Interest, Other Than Ownership Interest of Less Than 5% In A Publically Traded Company, That Provides Implantable Devices? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide name and address of entity below.)	
Name of Entity:	
Address:	
City:	State: Zip:

I declare under penalty of perjury that I have examined all statements contained herein and they are true, correct and complete, to the best of my knowledge and belief. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

Signed this _____ day of _____,

Signature of Physician