AmTrust North America
An AmTrust Financial Company

West Virginia
Worker's Compensation
Claim Kit

(p) 888.239.3909 • (f) 678.258.8399 • www.amtrustfinancial.com

AmTrust North America
An AmTrust Financial Company

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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 "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

Form OIC-WC-2

West Virginia Workers' Compensation
Employers' Report of Occupational Injury or Disease

PLEASE PRINT OR TYPE

Section I — Employer Information

Insurer:		**Third-Party Administrator:** AMTRUST NORTH AMERICA	
Employer's Name:	Nature of Business:		FEIN:
Address:			
City:	State:	Zip:	Telephone: ( ) -

Section II — Employee Information

Name: (Last):	(First):	(M.I.):	**Occupation/Job Title:**
Address:			**Telephone:** ( ) -
City:	State:	Zip:	**Social Security No.:** - -
Date of Birth: ____/____/____	**6. Sex:** ☐ M ☐ F		**Marital Status:**
Injured Employee is (check all that apply): ☐ Full-Time ☐ Part-Time ☐ Volunteer ☐ Owner/Partner ☐ Officer ☐ Retired – Date Retired: ____/____/____			**Employee's Occupation/Job Title:**

Section III — Information Regarding Injury or Disease

Date of Injury or Last Exposure: ____/____/____ **Time:** ☐ a.m. ☐ p.m.		**Witnesses to Injury:**
Date Employer Notified of Injury or Disease: ____/____/____	**Supervisor to whom Injury or Disease Reported:**	
If Injury was Fatal, Indicate Date of Death: ____/____/____		
Did Injury Occur on Employer's Property? ☐ Yes ☐ No Address or location where injury occurred:		

What was the Employee Doing when Injury Occurred (loading truck, walking down stairs, etc.)**:**

How did the Injury or Disease Occur (be specific; include time that employee began work on the date of injury, any equipment, tools, substances or objects connected to the injury; attach additional sheet if necessary)**:**

Nature of Injury or Disease (cut, bruise, strain, etc.):

Body Part(s) Injured:

Are You Aware of, or Do You Suspect, a Prior Injury to this Body Part? ☐ Yes ☐ No

Do You Have Reason to Question this Injury? ☐ Yes ☐ No (If "yes," attach a specific explanation to this form).

Location of Initial Treatment: **Emergency Room?** ☐ Yes ☐ No **Hospitalized?** ☐ Yes ☐ No

Section IV — Wage and Lost Time Information

Date Hired: ____/____/____	**Last Day Worked After Occupational Injury or Disease:** ____/____/____	
Number of Work Days Lost:	**Date of Return to Work:** ____/____/____	**Hours Worked per Week:**
Is Light Duty Available? ☐ Yes ☐ No	**Wage on Date of Injury: $** per ☐ hour ☐ day ☐ week ☐ month	
Are Wages Being Paid to Injured Employee During Disability? ☐ Yes ☐ No	**If Employee has Returned to Work, is it Alternative or Modified Work?** ☐ Yes ☐ No If "yes," indicate current wage: **$** per ☐ hour ☐ day ☐ week ☐ month	
Daily rate of pay on the date of injury: $	**and best quarter wages of preceding four quarters** $	

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law, specifically West Virginia Code §61-3-24e, provides for severe penalties if I knowingly certify a false report or statement and/or withhold a material fact regarding any information requested. I acknowledge the provisions of the aforementioned code and the severe penalties for knowingly with fraudulent intent aiding or abetting anyone in securing or attempting to secure benefits to which he or she is not entitled.

Print Name: _____ **Title:** _____

Signature: _____ **Date:** _____/_____/_____

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!

NOTICE TO EMPLOYEES

WORKERS' COMPENSATION

Employer Name: _____

The above named employer, an employer within the meaning of the Workers' Compensation Law of the state of __West Virginia_____, hereby gives notice to employees that the employer has secured the payment of Compensation to its employees and their dependants in accordance with the provision of the said law, by insuring with:

Insurance Company:

Policy Effective Date: _____

Policy Number: _____

If you are injured on the, or contract an occupational disease, notify the employer immediately.

Claims Administered By: AmTrust North America
P.O. Box 94405
CLEVELAND, OH 44101

Collecting Workers' Compensation benefits by intentionally misrepresenting, misstating, or failing to disclose any material fact is **fraud**. Fraudulent claims are subject to prosecution. All suspected violation will be investigated. Anyone may report a potentially fraudulent claim by contracting the Office of the Inspector General (OIG) Fraud Unit.

 Date Posted: _____

Form OIC-WC-1

West Virginia Workers' Compensation
Employees' and Physicians' Report of Occupational Injury or Disease

PLEASE PRINT OR TYPE

Section I — Employee's Claim Information

Insurer: **Third-Party Administrator:** AMTRUST NORTH AMERICA

1. Name: (Last): (First): (M.I):

2. Address: **3. Telephone:** ( ) -

City: State: Zip: **4. Social Security No.:** - -

5. Date of Birth: _____/_____/_____ **6. Sex:** ☐ M ☐ F **7. Marital Status:**

8. Date of Injury or Last Exposure: _____/_____/_____ **Time:** ☐ a.m. ☐ p.m. **9. Time You Began Work on Date of Injury:** ☐ a.m. ☐ p.m.

10. Date You Stopped Working Due to Injury: _____/_____/_____

11. Have You Retired? ☐ yes ☐ no If "yes," what was the date you retired: _____/_____/_____

12. Employer's Name: Supervisor's Name:

Address:

City: State: Zip: Telephone: ( ) -

13. Job Title/Description:

14. Body Part(s) Injured:

15. Describe How Your Injury Occurred (Specify the cause, what you were doing, and equipment/objects involved):

16. Did Injury Occur on Employer's Property? ☐ Yes ☐ No Address where injury occurred:

17. Please Identify Any Witnesses to Your Injury:

I certify that the above is true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I hereby authorize any physician, chiropractor, surgeon, practitioner or other healthcare provider, any hospital, including Veterans' Administration or governmental hospital, and medical service organization, any insurance company, any law enforcement or military agency, any government benefit agency including the Social Security Administration, or any other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to the diagnosis, treatment and/or counseling for HIV/AIDS, psychological conditions, and/or alcohol or substance abuse, for which I must give specific authorization. A Photostat of this authorization shall be as valid as the original.

Employee's Signature: _____ **Date:** _____/ _____/ _____

Section II — All Information Must Be Completed by Initial Healthcare Provider

1. Name of Physician/Hospital: **2. FEIN/Social Security No.:** - -

3. Address:

City: State: Zip: **Telephone:** ( ) -

4. Date of Initial Treatment: _____/_____/_____ **5. Date Patient May Return to Work:** _____/_____/_____

6. Have you advised the patient to remain off work 4 or more days?

☐ Yes. Indicate dates: from to

☐ No. If "no," is the patient capable of ☐ Full Duty ☐ Modified Duty If the patient is capable of returning to modified duty, specify any limitations/restrictions:

7. Condition is a direct result of: ☐ Occupational Injury? ☐ Occupational Disease? ☐ Non-Occupational Condition?

8. Did this injury aggravate a prior injury/disease? ☐ Yes ☐ No. If Yes, explain:

9. Description of injury or occupational disease:

10. Body part(s) injured: **11. ICD9-CM Diagnosis Code(s) in order of severity:**

12. Name of physician referred to: **13. If the patient was hospitalized, where?**

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge I have been informed of my responsibilities under West Virginia's Workers' Compensation Law and agree to abide by such in the administration of services provided thereunder. I understand the submission of false statements or billing may result in prosecution under state and federal law. I further agree to release any office notes/test results immediately to the employer or their representative.

Signature: _____ **Date:** _____/_____/_____

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					
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16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					