SOUTH CAROLINA

FHM INSURANCE COMPANY

A POLICY TO **DO MORE**®

Workers' Comp Since 1954

SOUTH CAROLINA-SPECIFIC
WORKERS' COMPENSATION INFORMATION
http://www.wcc.sc.gov/

DRUG-FREE WORKPLACE

Drug-Free Workplace

- 5.0% premium credit
- Companies self certify DFWP program through application (NCCI form 39-1) and are verified prior to adding credit.
- The Drug-Free Workplace Application, as well as other forms, is available at our web site, **www.fhmic.com**.

Training

Supervisors 2 hours, Employees 2 hours

SAFETY

Workplace Safety Programs

No state specific requirements or premium credit provided.

OSHA Information

South Carolina is a state OSHA plan state (Region 4). Office locations are:

1. Office – Mailing: South Carolina Department of Labor, Licensing, and Regulation Office of OSHA Compliance, P.O. Box 11329 Columbia, SC 29210

2. Office – Physical: Koger Office Park, Kingstree Building 110 Centerview Drive Columbia, South Carolina 29210 (803) 896-4300.

Safety Resources*

- **http://www.llr.state.sc.us/Labor/scovp/index.asp?file=list.htm**
- **https://www.scdmvonline.com/DMVpublic/**
- **http://www.doc.sc.gov/InmateSearchDisclaimer.jsp**
- **http://www.sled.state.sc.us/sled/default.asp?Category=CATCH_SSN**
- **http://www.nsopr.gov**
- **http://www.usfsafetyflorida.com**
- **http://www.osha.gov/Publications/smallbusiness/small-business.pdf**

- **http://www.toolboxtopics.com**
- **http://www.tdi.state.tx.us/wc/safety/videoresources/index.html**
- **http://www.msdssearch.com**
- **http://www.ehs.cornell.edu/msds/msds.cfm**
- **http://www.oshainfo.gatech.edu/**
- **http://www.ehs.okstate.edu/programs.htm**
- **http://siri.org/.**
- **http://www.free-training.com**
- **http://www.fhmic.com/safetynet/posters/**
- **http://www.fhmic.com/policyholder/forms/**

WEBSITES TO ASSIST WITH HIRING AND SCREENING*

- **https://www.scdmvonline.com/DMVpublic/**
- **http://www.doc.sc.gov/InmateSearchDisclaimer.jsp**
- **http://www.sled.state.sc.us/sled/default.asp?Category=CATCH_SSN**
- **http://www.nsopr.gov**
- **http://www.backgroundchecks.com**
- **http://pacer.psc.uscourts.gov/register.html**
- **http://www.searchsystems.net/**

*For the most up-to-date websites, visit **www.fhmic.com/safetynet/resources**

WORKERS' COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

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

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD TO CHECK IF APPROPRIATE ☐ SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
AGENT NAME & CODE NUMBER		

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX ☐ Male ☐ Female ☐ Unknown	MARITAL STATUS ☐ Unmarried/Single/Divorced ☐ Married ☐ Separated ☐ Unknown	OCCUPATION/JOB TITLE EMPLOYMENT STATUS NCCI CLASS CODE	
PHONE	# OF DEPENDENTS			
RATE PER: ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE? ☐ YES ☐ NO		

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ☐ AM (☐) CANNOT BE DETERMINED ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL				CAUSE OF INJURY CODE
DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO		
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT 0 ☐ NO MEDICAL TREATMENT 1 ☐ MINOR: BY EMPLOYER 2 ☐ MINOR CLINIC/HOSP 3 ☐ EMERGENCY CARE 4 ☐ HOSPITALIZED > 24 HOURS 5 ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED		

OTHER

WITNESSES (NAME & PHONE #)			
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:
Enter all dates in MM/DD/YY format.

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

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

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

AGENT NAME & CODE NUMBER:
Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:
This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:
Indicate the employee's work status. The valid choices are:
Full-Time On Strike Unknown Volunteer
Part-Time Disabled Apprenticeship Full-Time Seasonal
Not Employed Retired Apprenticeship Part-Time Piece Worker

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

CONTACT NAME/PHONE NUMBER:
Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:
Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:
Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

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

EMPLOYER'S INSTRUCTIONS – cont'd

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

(eg. Acetylene cutting torch, metal plate)

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

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

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

(eg. Cutting metal plate for flooring)

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

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

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

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

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

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

DATE RETURN(ED) TO WORK:

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

South Carolina Workers' Compensation Commission
1612 Marion St. • P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: ___ - ___ - ____ Employer's Name: _____

Address: _____ Address: _____

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

Home Phone: ( ) - _____ Work Phone: ( ) - _____ Insurance Carrier: _____

Preparer's Name: _____ Preparer's Phone #: ( ) - _____

Date of Injury: _____
month day year

A. Total Wages Paid

1. Check Applicable Method:
   - ☐ Report of earnings of injured employee based on four completed quarters.
   - ☐ Report of earnings of injured employee who did not complete four quarters based on actual time worked.
   - ☐ Report of earnings of similar employee. Injured employee did not work sufficient time before alleged injury. Hire date: _____
   - ☐ Report of earnings of injured employee based on alternative method because Form 20 results in a compensation rate that is not fair and just (attach documentation to show how average weekly wage and compensation rate were calculated).

2. List total wages paid as reported to the Employment Security Commission on the Employer Quarterly Contribution and Age Reports during the four quarters immediately preceding the quarter in which the injury occurred. Do not include the quarter during which the injury occurred.

Quarter	Ending Date	Total Wages Paid
1st	_____	$ _____
2nd	_____	$ _____
3rd	_____	$ _____
4th	_____	$ _____

Total Paid 2. $ _____

3. List total value of other allowances of any character made in lieu of wages during four quarters above. 3. $ _____
4. Add lines 2 and 3. **TOTAL WAGES PAID:** 4. $ _____
5. List total number of weeks paid to employee during the four quarters immediately preceding the quarter in which the injury occurred. 5. _____

B. Average Weekly Wage

6. To calculate average weekly wage, divide total wages (line 4) by total weeks paid (line 5).
   AVERAGE WEEKLY WAGE: 6. $ _____

C. Compensation Rate

7. The general rule for calculating the compensation rate is to multiply average weekly wage (line 6) by .6667. Estimate compensation rate by multiplying average weekly wage (line 6) by .6667. See part 8 below to determine the actual compensation rate. 7. $ _____
8. The compensation rate is as follows (choose one):
   - ☐ The calculated compensation rate (line 7) applies. Enter amount from line 7 on line 8.
   - ☐ When average weekly wage (line 6) is less than $75.00, the compensation rate is the average weekly wage. Enter average weekly wage on line 8.
   - ☐ When the estimated compensation rate (line 7) is less than $75.00 and average weekly wage (line 6) is more than $75.00, the compensation rate is $65.00. Enter $75.00 on line 8.
   - ☐ When the estimated compensation rate (line 7) is more than the maximum compensation rate for the year in which the injury occurred, enter the maximum compensation rate for the year in which the injury occurred on line 8.
   - ☐ Employee is within the exceptions listed in S.C. Code Ann. Section 42-7-65. List applicable exception here and enter appropriate compensation rate on line 8. _____

WEEKLY COMPENSATION RATE: 8. $ _____

Employer's representative shall prepare a Form 20 and serve per R.67-211 a copy on the claimant within thirty days of beginning temporary compensation. See R.67-1603 when no temporary compensation is paid. NOTE: Average weekly wage represents average gross pay before taxes and other deductions. WHEN THE CLAIMANT DOES NOT AGREE WITH THE COMPENSATION RATE ON LINE 8, HE OR SHE SHOULD CONTACT THE EMPLOYER'S REPRESENTATIVE TO TRY TO REACH AN AGREEMENT AS TO THE COMPENSATION RATE. IF NO AGREEMENT CAN BE REACHED, THE CLAIMANT SHOULD CONTACT THE CLAIMS DEPARTMENT AT (803)737-5723.

South Carolina Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5708

EMPLOYER'S WITHDRAWAL OF ELECTION TO ADOPT THE SOUTH CAROLINA WORKERS' COMPENSATION ACT

This form is required if an employer who elected to adopt the Workers' Compensation Act, being previously exempt as prescribed in Section 42-1-360 of the Act, now desires to withdraw its election.

Date: _____, _____.

To the South Carolina Workers' Compensation Commission:

The undersigned employer, who has voluntarily elected to operate under the South Carolina Workers' Compensation Act, being previously exempt as prescribed under Section 42-1-360 of the Act, withdraws that election to operate under the Workers' Compensation Act.

As provided by law (Section 42-1-390), the employer must give notice in writing to the Commission that the business shall no longer operate under the S.C. Workers' Compensation Act.

This rejection takes effect sixty (60) days after the date it is received by the South Carolina Workers' Compensation Commission.

*** * PLEASE PRINT OR TYPE ALL INFORMATION * * ORIGINAL SIGNATURES REQUIRED * ***

SWORN TO AND SUBSCRIBED BEFORE ME at

_____

this _____ of _____ , _____

_____
Notary Public for South Carolina

My Commission Expires: _____

For Official Use Only:

Date Received:	
Effective Date:	
Approved By:	
Telephone Number:	

EMPLOYER

_____
Name of Business (Legal Name)

_____
Federal I.D. #

_____
Street Address Post Office Box

_____
City State Zip Code

By: _____
Name and Title

_____
Signature of Employer Official Date

_____
Area Code Telephone Number

Reference Summary: Sections 42-1-310, 42-1-380, and 42-1-390. For more information about the provisions of these Sections and this form, please contact the Commission at the address above.

South Carolina Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5706

CORPORATE OFFICER NOTICE TO REJECT

To the Employer of the Undersigned and the Employer's Insurance Carrier:

The undersigned officer rejects the terms, conditions, and provisions of the South Carolina Workers' Compensation Act and elects to pursue compensation for personal injuries under the common law and statutes of South Carolina.

As provided by law (Section 42-1-520), "An officer of a corporation who elects not to operate under this title shall, in any action to recover damages for personal injury or death brought against an employer accepting the compensation provisions of this title, proceed at common law and the employer may avail himself of the defenses of contributory negligence, negligence of a fellow servant, and assumption of risk, as such defenses exist at common law."

This notice becomes effective on the date listed below, no sooner than the day following the date signed by the corporate officer.

** PLEASE PRINT OR TYPE ALL INFORMATION ** ORIGINAL SIGNATURES REQUIRED **

Name of Officer | Corporate Title

Street Address | P.O. Box

City | State | Zip

Social Security Number

Area Code | Telephone Number

Signature of Officer | Date

Name of Business (Legal Name)

Street Address | P.O. Box

City | State | Zip

Federal Employer ID #

Area Code | Telephone Number

Effective Date

Subscribed and sworn to me this _____ day of _____, _____.

Notary Public | My Commission Expires: _____

This form may be used when an officer desires to become exempt from the provisions of the South Carolina Workers' Compensation Act. For additional information regarding the provision of Section 42-1-520 and this form, contact your insurance carrier or the South Carolina Workers' Compensation Commission, Coverage Division, Post Office Box 1715, Columbia, South Carolina 29202-1715. (803) 737-5706.

NO INJURY CERTIFICATE

Employer: _____

Location/Department: _____

(Initial and complete as appropriate)

___ I have not suffered any injury during my employment period _____ (date) through _____ (date).

___ I suffered an injury to my _____ (part of body) on _____ (date) during my employment, which was (___) was not (___) reported to my supervisor _____ (name).

I have (__) or have not (__) witnessed an accident resulting in injury to someone else.

IMPORTANT NOTICE: **THIS REPORT IS FOR INJURY REPORTING PURPOSES ONLY. AN EMPLOYER MUST PAY WAGES EARNED BY AN EMPLOYEE WITHOUT IMPOSING ANY CONDITIONS SUCH AS SIGNING THIS FORM. NO EMPLOYEE WILL BE REQUIRED TO FILL OUT THIS FORM IN ORDER TO RECEIVE HIS OR HER WAGES.**

I certify that I have signed this form freely and voluntarily for reporting purposes only.

_____ _____

Employee Signature Date

REFUSAL OF TREATMENT

TODAY'S DATE: _____

EMPLOYEE NAME: _____

As of the date noted above I am notifying my employer of an injury that occurred on

(DATE):_____

- ❑ My supervisor did not receive notification of this incident.
- ❑ My supervisor did receive notification of this incident on (DATE): _____

This injury, (briefly describe condition) _____

_____

did occur during my normal scope and duties.

At this time I have been requested by my employer to be medically evaluated by a *preferred medical provider*. However, ***I decline to be medically evaluated for the above noted condition***.

I understand that by signing this document any future claims regarding this injury will require a medical evaluation by the preferred healthcare provider listed below. I also understand that should I decide to seek medical treatment for this injury that I must first notify my supervisor and go to the following provider:

PROVIDER: _____

ADDRESS: _____

PHONE: _____

SHOULD THE CONDITION BECOME LIFE THREATENING YOU SHOULD SEEK APPROPRIATE EMERGENCY MEDICAL CARE.

EMPLOYEE STATEMENTS

By signing this form I acknowledge:

I have not sought medical treatment for this injury.

I understand that it is the policy of my employer to have a post-accident drug screen and this refusal of medical treatment does not remove the requirement that I receive a post-accident drug screen.

I have read the above information and agree it is factual and a true statement. I authorize any physician, hospital, or healthcare provider to release and furnish any, and all, medical records or other information pertaining to the above listed condition.

_____ _____

Employee Signature **Supervisor / Witness Signature**

_____ _____

Date **Date**

06/11

Introductory Letter to Physician

AmeriSys / Coventry

Date: _____

Employer Name: _____

Employer Telephone Number: _____

Dear Dr. _____ :

_____ is scheduled for an initial visit as an employee of _____ which is a participant in the **FHM Insurance Company/Coventry Network**. This letter does not confirm that the injury or condition is covered by Workers' Compensation insurance. That determination will be made as soon as our claims administrator, United Self Insured Services, completes an investigation.

DRUG TESTING IS REQUIRED:

☐ Urinanalysis

☐ Breathalyzer (blood test if necessary)

We are working closely with Coventry and the involved medical providers to ensure that our employees receive access to timely and medically necessary treatment for their industrial injuries. In the best interest of our employees, we will have modified work available, which would allow the employee to return to work at the earliest possible date. Please keep this in mind as you treat this employee.

PLEASE CONTACT UTILIZATION MANAGEMENT
AT 407-351-1212/888-346-3461
WHEN ONE OF THE FOLLOWING OCCURS:

1. New Injury with Disability > 7 Days & No Release to Return to Work
2. Hospitalization
3. Anticipated Surgery
4. Physical Therapy or Chiropractic Treatment Recommended
5. Referral to Provider
6. Assistance Required to Return Injured Employee to Work
7. Repeat Major Diagnostic Studies

All claims for treatment must be submitted to the address below on a HCFA 1500, UB 92 or the appropriate form required by the State. Please submit all medical reports within the time frame required by the applicable state law:

FHM Insurance Company
P.O. Box 616648, Orlando, FL 32861-6648
407-351-1212/888-346-3461 Ext 353

Should you have any questions regarding your participation in the Coventry Network, please refer to the Coventry Provider Relations Unit- 800-937-6824 or contact your representative at: Coventry Workers' Comp Services, Attn: Stephanie Claycomb, 720 Cool Springs Blvd., #300 Franklin, TN 37067

Sincerely,

_____ _____

Print Name **Signature**

Pharmacy Instruction Letter

Dear Injured Worker:

Your employer's Workers' Compensation carrier, FHM Insurance Company, has joined together with AmeriSys and myMatrixx Pharmacy Program to provide you with a quick and convenient way to get your Workers' Compensation prescription drugs. The program allows you as a member to enjoy the following:

- No out-of-pocket payments
- No need to fill out or file claim forms related to your outpatient prescription drugs
- Major pharmacy chains in the network offering quick and convenient service

Use the myMatrixx Pharmacy Form (for initial prescriptions only), given to you by your employer when you report an injury, at any of the pharmacies listed on the form. A few days after the injury is reported you will receive a prescription card from myMatrixx.

Walgreens	**Eckerd Drugs**
Publix	**Winn-Dixie**
K-Mart	**Kash N Karry**
CVS	**Wal-Mart**

If you do not have one of those pharmacies in your area, the network includes the following chains:

Target	Harco
Rite-Aid	Golden Eagle
Brunos	Medicine Shoppe
Giant Eagle	

In addition to the major chains listed above, there are other pharmacies in the **myMatrixx** program**.** If your pharmacy of choice is not listed above, please contact **myMatrixx** at 877-804-4900 to see if it is included in the network. If the pharmacy is not yet enrolled, they can be contacted about participating in the **myMatrixx Pharmacy Program.**

Reminder: ***The myMatrixx Pharmacy Form you are given by your employer is for initial prescription(s) only. It is essential that you keep in touch with your adjuster at FHM Insurance Company, 888-346-3461 or 407-351-1212. You will receive an RX card direct from myMatrixx which should be used for any subsequent prescriptions.***

If you have any questions about the **myMatrixx** program, please contact your Nurse Case-Manager at 888-346-3461.

Dear Employee: You are being sent for medical treatment or evaluation for an apparent work-related injury. Should you need prescriptions filled, please provide this form to the pharmacy for initial prescriptions only. In a few days you will receive a prescription card from myMatrixx. **The pharmacy will need your Date of Injury, Date of Birth, Social Security Number and the Group Number which is 10602144.**

Dear Pharmacist: This employee is being treated for an apparent work-related injury. Please provide a 3-day supply in accordance with the formulary.

Pharmacy Input Codes:

Wal-Mart	PP	Publix	PSP
Winn-Dixie	PRS	K-Mart	PSP
Eckerd	2343	Walgreens	PPSC
Target	PSP	Rite-Aid	PRESCRIP
Kash N Karry	PPSC	Golden Eagle	PSP
Medicine Shoppe	PSP	CVS	5792
Giant Eagle	PSP	Harco	PRESCRIP
Brunos	PPSC		

Independent pharmacies will use BIN#014211 (may be listed as Stockton Group or Pharmacy Plus).

Pharmacy: Please leave "person code" blank. **Group Number is 10602144**
If there are any questions, please contact myMatrixx at 877-804-4900.

myMatrixx Pharmacy Form

cut here ----------

Dear Employee: You are being sent for medical treatment or evaluation for an apparent work-related injury. Should you need prescriptions filled, please provide this form to the pharmacy for initial prescriptions only. In a few days you will receive a prescription card from myMatrixx. **The pharmacy will need your Date of Injury, Date of Birth, Social Security Number and the Group Number which is 10602144.**

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Medicine Shoppe	PSP	CVS	5792
Giant Eagle	PSP	Harco	PRESCRIP
Brunos	PPSC		

Independent pharmacies will use BIN#014211 (may be listed as Stockton Group or Pharmacy Plus).

Pharmacy: Please leave "person code" blank. **Group Number is 10602144**
If there are any questions, please contact myMatrixx at 877-804-4900.

myMatrixx Pharmacy Form

EMPLOYEE AGREEMENT
EMPLOYEE SAFE WORKING PRACTICE/MANAGED CARE

As a condition of employment, I _____ do hereby agree to
(Please print full name)
comply with the following Employee Safe Working Practices and Managed care program.

1. I agree to follow established departmental safety procedures.

2. I agree to report any work-related accident or injury to my supervisor as soon as it occurs, but no later than the end of my duty shift.

3. If I need treatment for a work-related injury, I understand that my employer has enrolled in a Managed Care Program for Workers' Compensation with ***FHM Insurance Company WECARE Program and AmeriSys/Coventry Network*** and that the following procedures must be followed for all work-related injuries and illnesses. Treatment received outside the Workers' Compensation managed care arrangement is not compensable unless authorized by the carrier prior to the treatment date.

    - ✓ Report promptly any work-related injury to supervisor.
    - ✓ Hand carry the Introductory Letter to Physician to the approved network physician on the initial visit.
    - ✓ Follow the approved network physician's instructions for any additional specialist treatment, if needed.
    - ✓ **Ensure all medical treatment is handled only through the approved network physician.**
    - ✓ Direct all questions about level of care to the approved network physician, who is the focal point for medical treatment.
    - ✓ Follow your state's established procedures to resolve dissatisfaction with medical treatment.

I understand that failure on my part to follow the above procedures could result in disciplinary action not to exclude termination and loss of Workers' Compensation benefits.

I also understand that according to Workers' Compensation Law, my compensation benefits could be reduced for any injury that occurs because of failure to follow established safety procedures.

_____ _____
Employee Date

_____ _____
Witness Signature Date

Original to Personnel File / Copy to Employee

WORKERS' COMPENSATION WECARE NETWORK
PROVIDER NOMINATION FORM

All information in the box below must be completed prior to forwarding.
The form will be returned if incomplete.

Employer Name:	
Address:	
City, State, Zip:	
Telephone #:	
Requestor Name:	
Requestor Telephone #:	
Provider Name:	
Group Name:	
Provider Specialty:	
Address:	
City, State, Zip:	
Telephone #:	
Client's $ volume with provider:	
Period represented:	From: To:
Source of Data (1099):	
Other:	

Tax ID # (if available): _____

Contact Person (if available): _____

Hospital Affiliation (if known): _____

Reason for Nomination: _____

Comments: _____

Signature: _____ Date: _____

Please forward to:

AmeriSys
Attn: Leslie Whittemore
PO Box 616648
Orlando, FL 32861-6648
888-346-3461 x120 / Fax #: 407-949-3170

Internal Use Only:
Date Received: _____
Recruitment Letter Sent:
Date of Last Contact:
Current Status: _____

Managed Care Representative: _____

FHM Insurance Company

WECARE®

WORKERS' COMPENSATION

DISSATISFACTION OF SERVICES PROCEDURE

IF YOU ARE INJURED ON THE JOB

Your employer and Workers' Compensation carrier are concerned that you receive appropriate medical treatment.

Your employer has a list of health care providers and can assist you in selecting a provider from within the Coventry Network. If you need to be referred to another provider or need emergency care, you may choose from the list of providers participating in the Network.

If you are dissatisfied or have questions concerning the medical care and treatment provided by a **WECARE** provider, you may, within one year from the date of treatment or care in question, file a complaint by contacting Amerisys at 888-346-3461 x417.

Amerisys staff and/or Nurse Case-Manager will coordinate a resolution to the complaint and contact a Physician Advisor if necessary. The Physician Advisor may require medical examinations and/or other information from you and the Network provider depending on the nature of the dispute. If the Physician Advisor is unable to resolve the dispute to your satisfaction within ten (10) days, the matter will automatically be referred to the Medical Director.

The Medical Director will issue a decision within thirty (30) days unless further information is required, in which case an additional thirty (30) days will be allowed. If an agreement is not reached and you are not satisfied with the decision of the Medical Director, you may file a request for reconsideration with the Division of Workers' Compensation.

If you have any questions concerning the Coventry Network, call 888-346-3461, ext. 120 or write to:

Coventry Health Care Workers' Compensation, Inc.
3200 Highland Avenue
Downers Grove, IL 60515

AmeriSys
Dispute Resolution Form

Employee Name:	Provider Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Phone #	Phone #
SS#:	SS#:

Please describe your dissatisfaction with services in detail below. Include dates, names and the specific resolutions which you feel would remedy the situation. Then mail this form to the address noted below or call 800-752-0886, Cheryl Gulasa RN, CPUR, CCM

Issue: Service _____ Medical Care _____ Other: _____

Date of injury: _____ Date of dissatisfaction: _____

Please describe:

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature Date

_____

Cheryl Gulasa, Dispute Resolution Coordinator

AmeriSys★

140 Alexandria Blvd., Suite H
Oviedo, FL 32765

(800) 752-0886

APPLICATION FOR POST-INJURY DRUG AND/OR ALCOHOL TESTING PROGRAM

TO:	FHM Underwriting Department	Fax No: 407-373-6441	Date:	

INFORMATION NEEDED TO REGISTER YOUR COMPANY

(Please complete all information on this page and fax to FHM Policy Services Department)

GENERAL INFORMATION

Policy No.	306-				
Company Name:					
D/B/A:					
Street:					
City:		State:		Zip:	
Phone:		Fax:			
Contact:		Email:			

YES, I am interested in registering my Company for this program:

MANAGED CARE PROVIDER INFORMATION

(Where you send your injured employee for treatment)

Provider Name:					
Street:					
City:		State:		Zip:	
Phone:		Fax:			
Contact:		Email:			

Provider Name:					
Street:					
City:		State:		Zip:	
Phone:		Fax:			
Contact:		Email:			

NO, I am not interested in registering my Company for this program:

Reason please: _____

_____

PLEASE NOTE: Your company will be responsible for the costs of drug tests conducted at a designated medical center or collection site for tests that are **NOT** part of the FHM *"Post-Accident Drug Testing Program"* (examples are: (1) Post-accident testing in which a claim is not reported; (2) Pre-Employment; (3) Random & reasonable suspicion). Also, you are **NOT** set-up to do post-accident testing until you receive *"chain of custody"* forms and further instructions from **Total Compliance Network (TCN)** – (800) 881-4826.

Company Official's Signature:			
Print Name:		Title:	

CONSENT TO EMPLOYEE DRUG AND/OR ALCOHOL TESTING

I understand that submission to a Post-Injury Drug And/Or Alcohol Screen is a condition of employment with this employer. I understand that, should my testing results be confirmed positive or I refuse to test, I will be subject to the company's disciplinary action, including possible discharge. I understand that a tampered with or an adulterated specimen will be considered a refusal to test, resulting in possible discharge.

I hereby give my consent to release the results of my blood and/or urinalysis to the person(s) or department(s) or the specified agent of my employer, including my employer's Workers' Compensation Insurance Company, for the purpose of determining the presence of alcohol and/or other drugs in my body for the duration of my employment.

I understand that if I am injured during the course and scope of my employment and I test positive for the presence of alcohol and/or drugs, I may forfeit my eligibility for medical and indemnity benefits. I also understand that a refusal to test, a tampered with or an adulterated specimen under this circumstance may also result in forfeiture of my eligibility for medical and indemnity benefits and immediate action, including possible discharge.

By signing this form, I hereby release to the Company and/or Company's Medical Review Officer the results of the test(s) to which I have consented. I further authorize the Company to discuss the results with medical personnel / physician collecting the specimen, the testing facility, its directors, officers, agents, and employees responsible for administering the aforementioned test(s) or evaluating the results thereof and any of them herein. I also authorize the Company to discuss the results with its legal advisors and to use the test results as a defense to any legal action to which I am a party.

I further release any testing facility or any physicians who have tested me from any liability arising from a release of any and all results, written reports, medical records, and data concerning my test(s) to the appropriate Employer officials. I agree to have the results released to the Company and/or the Company's Medical Review officer.

Employee or Applicant Signature:_____ Print Name:_____ Date:_____
(Parent or Guardian Signature if Employee is a Minor)

Employee or Applicant SS#:_____ Witness:_____ Date:_____

OR

I hereby refuse to consent to submit testing for the presence of drugs and/or alcohol.

Employee or Applicant Signature:_____ Print Name:_____ Date:_____
(Parent or Guardian Signature if Employee is a Minor)

Employee or Applicant SS#:_____ Witness:_____ Date:_____