

01 One good reason to think twice about workers' compensation fraud



EMPLOYERS® actively investigates suspected workers' compensation fraud and reports such cases to law enforcement authorities.

fraud costs

Workers' compensation fraud costs \$7.2 billion annually.¹

Filing a fraudulent workers' compensation claim could lead to serious civil or criminal consequences, such as fines, incarceration and/or restitution.

If you suspect workers' compensation fraud, please contact EMPLOYERS' Fraud Investigations Department. Call the Fraud Hotline at 1-800-750-3939 or e-mail fraudfighters@employers.com.

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1 Source: <http://www.propertycasualty360.com/2015/07/23/3-keys-to-a-successful-workers-compensation-fraud>

Una buena razón para pensarlo dos veces antes de cometer fraude en una demanda de indemnización laboral



EMPLOYERS® investiga de manera activa casos sospechosos de cometer fraude en una demanda de indemnización laboral y reporta dichos casos a las autoridades policiales.

costos del fraude

Fraude en demandas de indemnización laboral cuesta \$7.2 mil millones al año.¹

Presentar una demanda de indemnización laboral fraudulenta puede acarrear graves consecuencias civiles o penales, tales como multas, cárcel y/o indemnizaciones.

Si sospecha que existe fraude en una demanda de indemnización laboral, póngase en contacto con el Departamento de Investigación de Fraude de EMPLOYERS. Llame a la línea directa de fraude al 1-800-750-3939 o escriba al correo electrónico fraudfighters@employers.com.

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1 Fuente: <http://www.propertycasualty360.com/2015/07/23/3-keys-to-a-successful-workers-compensation-fraud>

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 person:



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 pharmacy will fill the prescription at no cost to you.



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



Employer:

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





Finding a network pharmacy

Most pharmacies 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

America's small business insurance specialist[®]

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Employers

CARRIER/TPA _____ EMPLOYER _____

INJURED PERSON 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	or	Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	EMPLFF		

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

HACEMOS MÁS SENCILLO QUE SE LE ABASTEZCA LAS RECETAS DE SU 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 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.

Persona lesionada:



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 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.



Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información que aparece a continuación y entregue este formulario al empleado.



Cómo encontrar una farmacia de la red

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



¿Tiene alguna pregunta? ¿Necesita ayuda?

1-866-599-5426




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WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Employers

PORTADORA _____ EMPLEADOR _____

NOMBRE DEL PERSONA LESIONADA _____

Please provide directly to Pharmacist

NUMERO DE SEGURO SOCIAL _____ FECHA DE LA 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	EMPLFF		

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



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Basic Accident Report

Date of Report: _____ Report Completed By: _____

Last Name of Injured Person:	First Name:	Job Title:
Date of Accident:	Time of Accident:	Location of Accident:
Supervisor's Name & Job Title:	Name of Witnesses:	
Full Description of Injuries:		
Description of accident/incident or employee's account, including sequence of events preceding the accident:		
Basic cause and contributory causes. Explain fully unsafe act, unsafe condition, personal factor, other:		
Recommended Corrective Measures:	Action By:	
Names of Inspection Team Participants:		
Management Review By:	Date to be Completed By:	

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Informe Básico de Accidentes

Fecha Del Informe: _____ Informe Completado Por: _____

Apellido De La Persona Lesionada:	Primer Nombre:	Puesto De Trabajo:
Fecha Del Accidente:	Hora Del Accidente:	Lugar Del Accidente:
Nombre Del Supervisor Y Cargo:	Nombre De Los Testigos:	
Descripción Completa De Las Lesiones:		
Descripción del accidente / incidente o versión del empleado, incluyendo la secuencia de eventos que preceden al accidente:		
Causas básicas y causas contributivas. Explique el tipo de situación ya sea si fue una situación insegura, condición insegura, factor personal, otros:		
Medidas Correctivas Recomendadas:	Acciones Tomadas Por:	
Nombres De Los Participantes Del Equipo De Inspección:		
Revisión Por Parte De La Gerencia:	Fecha Límite De Entrega:	

EMPLOYERS® y America's small business insurance specialist® son marcas registradas de Employers Insurance Company of Nevada. El seguro se ofrece a través de la Compañía de Seguros de Compensación del Empleador, la Compañía de Seguros del Empleador de Nevada, la Compañía de Seguros Preferida del Empleador y la Compañía de Seguros del Empleador. EIG Services, Inc. (en California, dba EIG Insurance Services) es una agencia afiliada y de peritaje. No todas las aseguradoras realizan actividades comerciales en todas las jurisdicciones.

WORKER'S COMPENSATION

STATE _____

CLAIM NO. _____

Report of Employee's Wages for period of _____ Weeks _____ Days

Please state employee's past wages for the 52-week period prior to the date of injury.

Please give fully and carefully all information requested.

This is IMPORTANT for Employer, Employee and Insurer.

Employer _____ Employee _____ SSN# _____

Date Employee ceased to work _____ How long employed? _____

hours

Number of days employee worked per week _____ Regular wages or piece work? _____

Did employee pay part of earnings to helpers? _____ If so, how much and to whom? _____

Is employee paid by hour, day, week or month? _____ At what rate? _____

WEEK	NO. DAYS	WEEK ENDING	GROSS WAGES	WEEK	NO. DAYS	WEEK ENDING	GROSS WAGES
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			

This is a correct statement of Employee's earnings as actually taken from our Payroll Records.

Employer By _____

DO NOT FILL IN

Number of weeks which statement covers _____ Number of Days lost _____

Number of weeks actually worked _____ Total amount paid _____

Average Weekly Wage _____

STATE OF ALABAMA WORKERS' COMPENSATION INFORMATION



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

Your employer will advise you of the physician to see for authorized medical treatment.

WORKERS' COMP INSURANCE
CARRIER _____

TELEPHONE NUMBER _____

**ASSISTANCE IS AVAILABLE UNDER THE ALABAMA WORKERS'
COMPENSATION LAW INCLUDING MEDIATION SERVICE.**

FOR INFORMATION CALL:

1-800-528-5166

Department of Labor

Workers' Compensation Division

649 Monroe Street

Montgomery, AL 36131

**CODE OF ALABAMA, 1975, § 25-5-290(d), REQUIRES THAT THIS NOTICE
BE POSTED**

IN ONE OR MORE CONSPICUOUS PLACES IN YOUR BUSINESS.

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE

CLAIM REFERENCE				
1. Insured Report Number	2. Filing Office Claim Number	3. OSHA Log Case Number		
EMPLOYER				
4. Employer Business Name		ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS		
5. Physical Address 1		10. Mailing Address 1		
6. Physical Address 2		11. Mailing Address 2		
7. City	8. State	9. Zip	12. City	13. State 14. Zip
15. Federal ID Number	16. U.C. Account Number		17. NAICS	
INSURER / FILING OFFICE				
18. Insurer Name		21. Filing Office Name		
19. Insurer Federal ID Number		22. Mailing Address 1		
20. Type Insurer		23. Mailing Address 2 or Telephone Number		
Ins Co <input type="checkbox"/> Self-Insurer <input type="checkbox"/> Group Fund <input type="checkbox"/>		24. City 25. State 26. Zip		
		27. Filing Office Federal ID Number		
EMPLOYEE / WAGES				
28. First Name		32. Employee ID Number		
29. Middle Name		33. Type Employee ID Number		
30. Last Name		SSN <input type="checkbox"/> Passport Number <input type="checkbox"/> Green Card <input type="checkbox"/>		
31. Last Name Suffix (ie. Jr., Sr., III)		Employment Visa <input type="checkbox"/> Assigned by Jurisdiction <input type="checkbox"/>		
34. Mailing Address 1		40. Gender		41. Date of Birth
35. Mailing Address 2		Male <input type="checkbox"/>		42. Nbr of Dependents
36. City		Female <input type="checkbox"/>		
37. State		38. Zip		39. Phone
43. Marital Status				44. Date Hired
Unmarried (Single or Divorced or Widowed) <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>				
45. Occupation Description			46. Number of Days Worked Per Week	
47. Wages \$		49. Received Full Pay For Day of Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		
48. Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/>		50. Did Salary Continue? Yes <input type="checkbox"/> No <input type="checkbox"/>		
INJURY / TREATMENT				
51. Date of Injury	52. Time of Injury	53. Time Employee Began Work	54. Date Disability Began	55. Date of Death
	a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unk <input type="checkbox"/>	a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		
PLACE OF ACCIDENT, INJURY, OR EXPOSURE			61. Injury Occurred on Employer's Premises?	
56. Site Address			Yes <input type="checkbox"/> No <input type="checkbox"/>	
57. City			62. Date Employer Notified	
58. State			59. Zip	
60. County				
63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)				
PROVIDE DESCRIPTION CODES to identify Nature of Injury, Part of Body that was affected, and Cause of Injury. (FOR COMPLETE LIST OF CODES, GO TO HTTP:// LABOR.ALABAMA.GOV/WC				
64. Nature of Injury Code		65. Part of Body Code		66. Cause of Injury Code
67. Initial Treatment		No Medical Treatment <input type="checkbox"/>		68. Name of Treatment Facility
First Aid By Employer <input type="checkbox"/>		Minor Clinic / Hospital <input type="checkbox"/>		
Emergency Room <input type="checkbox"/>		Hospitalized Overnight <input type="checkbox"/>		
Hospitalized > 24 Hours <input type="checkbox"/>		Outpatient Treatment <input type="checkbox"/>		
69. Address			70. City	71. State 72. Zip
73. Name of Physician or Other Health Care Professional			74. Has Injured Returned to Work	
			Yes <input type="checkbox"/> No <input type="checkbox"/>	
			If so, 75. Date	
			76. Time a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	
OTHER				
77. Date Prepared	78. Preparer's First Name	79. Last Name	80. Title	81. Preparer's Telephone Number