EMPLOYERS®

America's small business insurance specialist®

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:	

EMPLOYERS®

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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:	

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.

EMPLOYERS®

America's small business insurance specialist®

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

CM_0077IF_US
REV 09/2015

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.

EMPLOYERS®

America's small business insurance specialist®

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

CM_0077IF_US
REV 09/2015

COMMONWEALTH OF KENTUCKY

WORKERS' COMPENSATION NOTICE

Employees of this business are covered by the Kentucky Workers' Compensation Act (KRS Chapter 342). Conspicuous posting of this Notice is required by law.

Employer Name: _____
Address: _____
Workers Compensation Carrier
(or third party administrator): _____
Policy #:_____, effective _____ to _____
Address: _____
Telephone: _____, Contact Person _____

EMPLOYEES: IF INJURED – NOTIFY your supervisor IMMEDIATELY; when possible Notice should be in writing. FAILURE to notify your supervisor could result in denial of benefits. OBTAIN MEDICAL CARE. Your employer must pay for ALL NECESSARY MEDICAL CARE to treat a workplace injury. The employee may select the physician or medical facility to render care. If the employer is enrolled in an approved Managed Care Plan employee selection of physicians is LIMITED to the Approved Provider Network, except in certain emergencies. FOR INJURIES REQUIRING CONTINUING CARE the EMPLOYEE MUST DESIGNATE A TREATING PHYSICIAN, a form to do so will be furnished by your employer or its insurance carrier.

This employer IS ☐ IS NOT ☐ participating in a Managed Care Plan for medical care. The name of the Managed Care Plan is _____, its representative is _____, phone number _____.

DISABILITY BENEFITS to replace wages lost due to a workplace injury are payable under the Workers Compensation Act after seven (7) day of disability. A CLAIM MUST BE filed with the Department of Workers' Claim WITHIN TWO YEARS of the date of injury, or last payment of temporary total disability benefits.

NEED ASSISTANCE? Contact your employer's claim representative. If your questions about workers' compensation rights are not promptly answered call THE KENTUCKY DEPARTMENT OF WORKERS CLAIMS at 1-800-554-8601 to speak to an Ombudsman or Workers' Compensation Specialist.

EMPLOYER SUPERVISORS – NOTIFY MANAGEMENT IMMEDIATELY OF ALL INJURIES SO THAT TIMELY REPORT CAN BE MADE AS REQUIRED BY LAW.

04/09/09

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

PHONE

OF DEPENDENTS

NCCI CLASS CODE

RATE PER: | ☐ DAY ☐ WEEK ☐ MONTH ☐ 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 ☐ PM ( ) CANNOT BE DETERMINED | 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
☐ NO MEDICAL TREATMENT
☐ MINOR: BY EMPLOYER
☐ MINOR CLINIC/HOSP
☐ EMERGENCY CARE
☐ HOSPITALIZED > 24 HOURS
☐ 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.

EMERGENCY WORKSITE POSTER

To be Posted at Each Location

NOTICE TO ALL EMPLOYEES

IF YOU BECOME INJURED OR ILL AT WORK:

1. Notify your supervisor immediately about your work-related injury or illness. Your supervisor will call the EMPLOYERS Injured Employee Hotline at **855-365-6010** to initiate your claim.

2. If you need immediate medical attention, please go to the nearest hospital or urgent care facility.

FOR EMERGENCY CARE PROCEED IMMEDIATELY TO:

You may use any hospital or urgent care facility for emergency care.

3. Your supervisor will give you a *Channeling Letter* to help you find a provider. You can also call Coventry at any time at **1-800-937-6824**, select options 1, 1, and 1. A Coventry representative can help you locate a provider within the EMP KY MHCP, or assist in scheduling an appointment with a provider within the EMP KY MHCP. You may also visit the provider locator website at www.employers.com and choose the *For Injured Workers* tab and select Provider Locator, then Kentucky.

These medical providers have been chosen by your employer/carrier as first choice of emergency medical providers for injuries/illnesses sustained on the job. The EMP KY MHCP has been selected and is designed to help you receive timely and effective medical care and treatment for your work-related injuries and illnesses and to help you return-to-work as soon as medically possible.

America's small business insurance specialist®

EIG Services, Inc., an affiliated agency and adjuster

Employers Preferred Insurance Company | Employers Assurance Company
Employers Compensation Insurance Company | Employers Insurance Company of Nevada
CL_PH_0037_US_KY Rev 09/2017

***Instruction*:** *This letter should be provided to new employees at the time of hire and all current employees prior to the implementation of the EMP KY MHCP. The information on this letter should be placed on your company's letterhead. You should maintain documentation that you provided this information to your employees. The language on the Initial Employee Acknowledgement letter should not be modified or altered. However, you may add additional information if deemed appropriate–such as whom within the company employees should contact if they have questions about the letter.*

EMPLOYERS Kentucky Managed Health Care Plan (EMP KY MHCP) Initial Employee Letter

To All Employees:

Your employer's workers' compensation carrier - Employers Compensation Insurance Company, Employers Preferred Insurance Company, or Employers Assurance Company (EMPLOYERS), has implemented a plan to help employees when they sustain a work-related injury or illness. The plan is called the EMPLOYERS Kentucky Managed Health Care Plan (EMP KY MHCP) and is supported by Coventry Health Care Workers Compensation, Inc (Coventry), a national managed care company. Our goal in using this plan is to get you healthy and back to work as quickly as medically possible.

If you have a work-related injury or illness after 10/1/17 and require medical attention, you must obtain treatment from within the EMP KY MHCP network of providers. To help you find a provider, contact Coventry at 800-937-6824 or visit the provider locater website at www.employers.com and choose the *For Injured Workers* tab and select *Provider Locator*, then *Kentucky*.

Exceptions:
In an emergency, you may seek treatment from any hospital or emergency facility.

For non-emergency situations, you will need to use a provider from within the EMP KY MHCP. However, in some instances you may need to find necessary care outside the EMP KY MHCP. The EMP KY MHCP allows you to elect to receive services from an out-of-network provider under the following circumstances:

1) For emergency care

2) When you are referred outside the EMP KY MHCP for medical services by a Gatekeeper Physician
3) When authorized treatment is unavailable through the EMP KY MHCP
4) To obtain a second opinion when an EMP KY MHCP provider recommends surgery

You do not need prior approval to use emergency care. Please note that care needed after hours should be considered emergency care. For all other non-emergency care, you must obtain prior approval from a claims adjuster at 888-682-6671 to use an out-of-network provider.

If you had an injury or illness prior to your employer's participation in the EMP KY MHCP, and you are using a participating provider in the EMP KY MHCP, your continued care will now be managed under this plan. You will soon receive an employee EMP KY MHCP Claims Kit from the claims adjuster identifying your rights and responsibilities under the program.

If you had an injury prior to your employer's participation in the EMP KY MHCP program, and you are using an out-of-network provider, you may continue treating with your existing out-of-network provider. In the event you wish to change providers, you will be placed into the EMP KY MHCP and will need to use an in-network provider. You will receive additional communication from a claims adjuster in relation to your injury at that time. If you have questions, please contact EMPLOYERS at 888-682-6671.

During the course of your injury, you may receive a call from a Coventry nurse to assist you in receiving medical care, coordinating activities with your employer and provider and determining the best time for you to return to work. Wherever possible, Coventry will discuss with your employer all opportunities for you to return to work under modified or alternative duty until you can return to full duty and functionality.

You have a right to file a grievance if you are dissatisfied with the service provided to you within the EMP KY MHCP. A grievance is made when a written complaint or written request is delivered by the employee or provider to the EMP KY MHCP setting forth the nature of the complaint and remedial action requested. The employee or provider shall file a grievance within thirty (30) days of the occurrence of the event giving rise to the dispute. The EMP KY MHCP shall render a written decision within thirty (30) days of receiving a grievance. Any employee or provider dissatisfied with the EMP KY MHCP's resolution of a grievance may apply for review by an administrative law judge by filing a request for resolution within thirty (30) days of the date of EMP KY MHCP's final decision. Request for resolution should be submitted to the following:

Kentucky Department of Workers' Claims
657 Chamberlin Avenue
Frankfort, KY 40601
Phone: 502-564-5550

Employee Acknowledgement Form

Please sign and date this form in the space below to indicate that you have received this information. Return this signed and dated form to your supervisor.

By signing this form, I confirm the following:

- I have received an initial letter and information from my employer about the use of the EMPLOYERS® Kentucky Managed Health Care Plan (EMP KY MHCP) for any work-related injury or illness;
- That in the event I have a work-related injury or illness, my care will be supported under the EMP KY MHCP;
- That at the time of injury, I will:
  - Immediately notify my supervisor about my injury/illness
  - Obtain more information from my employer and EMPLOYERS about my role and responsibilities under this program, including how to locate a provider and utilize only the medical providers available through the EMP KY MHCP if I sustain a work-related accident or illness except in cases of emergencies.

I also understand that if I go to a medical provider that is not included as part of the EMP KY MHCP for treatment of a workers' compensation claim that this treatment **may not** be authorized. I also understand there is a dispute and grievance process in place for any concerns I may have regarding the EMP KY MHCP. I understand my rights and responsibilities within the certified EMP KY MHCP and agree to comply with its provisions.

Sign and return to your employer supervisor

_____
Employee Signature

_____ _____
Print Name Date

_____
Employer Name/Location

_____ _____
Employer Representative's Signature Date

Note – This Acknowledgement Form will be kept in your employee file to confirm your receipt of initial notice about your employer's participation in the EMPLOYERS Kentucky Managed Health Care Plan in the event you have a work-related injury or illness.

EIG Services, Inc.
In California, dba
EIG Insurance Services

EMPLOYEE NOTICE

Date

Physician Name
Physician Address
City, State, Zip

Re: Workers' Compensation Injury – Employee Notice

Employee / Empleado:	Employee First and Last Name
Employer / Empleador:	Employer Name
Claim Number / Num de Reclamo:	Claim Number
Date of Injury / Fecha de lesion:	Date of Injury
Insurer / Aseguradora:	Insurer Name

Dear Employee First and Last Name

Employer Name participates in the EMPLOYERS Kentucky Managed Health Care Plan (EMP KY MHCP). This plan works in combination with Employer Name's workers' compensation carrier, Insurer Name, and Coventry Health Care Workers' Compensation, Inc., a national managed care company. The EMP KY MHCP is a certified plan that provides access to medical care for employees who have work-related injuries or illnesses. The role of the EMP KY MHCP is to ensure that the medical and health care services you receive are provided in a timely and effective manner that is convenient for you, the injured employee.

Your care will be managed under the EMP KY MHCP. This notice provides an overview of the rules and responsibilities under the plan below:

- For general information about the EMP KY MHCP, you may contact Coventry at 800-262-6122. A live representative will be there during normal business hours (8 AM to 5 PM Central Time). After hours, you may leave a message and a representative will call you the next business day.

- If you need immediate, emergency treatment for your work-related injury or illness, go to the nearest hospital or urgent care facility. You may receive immediate emergency medical treatment 24 hours a day that is compensable from any medical provider or hospital.

- In a non-emergency situation, you must use a EMP KY MHCP provider. To help you find a provider, contact your claims adjuster at 888-682-6671 or visit the provider locater website at www.employers.com and choose the *For Injured Workers* tab and select Provider Locator, then Kentucky.

- A copy of the Initial Visit Provider Letter is attached. Please bring this letter to your initial visit and give it to the provider. This letter explains the role and responsibility of the provider under the EMP KY MHCP.

- When it becomes apparent that you need continued care, your treatment needs to be coordinated by a single EMP KY MHCP physician chosen by you. This will be your Gatekeeper Physician. A Gatekeeper Physician is a qualified physician acting within the scope of his or her license who has been specifically designated by the EMP KY MHCP to provide primary care to a patient and to make referrals of patients to other providers for specialized care or diagnostic services.

  You must provide notice of your selected "Gatekeeper Physician" and his/her acceptance within ten (10) days after starting treatment with him/her. To provide proper notification, you and your Gatekeeper Physician must complete and return Form 113 (see attached). A self-addressed, prepaid envelope is enclosed for returning the completed Form 113 to EMPLOYERS. If you do not complete and return within 10 days from the start of treatment, all benefits payable may be suspended until the form is completed and returned.

- Your Gatekeeper Physician can refer you to other providers for specialized care or diagnostic services. To be qualified as a Gatekeeper Physician, a provider:

  - Must be a EMP KY MHCP participating provider and designated as a Gatekeeper Physician; and
  - Must be primarily responsible for the treatment of your workers' compensation injury or illness

  In the event the physician you selected for a Gatekeeper does not qualify as a designated Gatekeeper Physician and does not meet the requirements of an eligible Gatekeeper Physician as described above, the claims adjuster will send you a communication to find another Gatekeeper that fits the specifications. You will have seven (7) days upon receipt of the claims adjuster communication to identify another Gatekeeper or additional services will be deemed as "not compensable."

- EMP KY MHCP regulations allow you to elect to receive services from an out-of-network provider under the following circumstances:
  - For emergency care
  - When the Gatekeeper Physician refers an employee outside the EMP KY MHCP for medical services
  - When authorized treatment is unavailable through the EMP KY MHCP
  - To obtain a second opinion when a EMP KY MHCP provider recommends surgery
  - For those injuries or diseases for which continuing treatment was initiated prior to the date the managed care plan for the employer was approved, the employee may continue treatment with their current physician
  - If initial emergency care following a compensable injury is treated by a medical provider outside the EMP KY MHCP, the injured employee may remain under the care of that provider so long as the provider complies with utilization review, reporting standards, and quality assurance mechanisms prescribed by the employer's managed care plan. To obtain approval to use an out-of-network provider, you may contact your claims adjuster at 888-682-6671.

- If you had an injury prior to your employer's participation in the EMP KY MHCP, and you are using a participating provider in the EMP KY MHCP, your continued care will now be managed under this program. You will soon receive an employee EMP KY MHCP Claims Kit from the claims adjuster identifying your rights and responsibilities under the program.

  If you had an injury prior to your employer's participation in the EMP KY MHCP, and you are using an out-of-network provider, you may continue treatment with your existing out-of-network provider. In the event you wish to change providers, you will then be placed into the EMP KY MHCP and will need to use an in-network provider. You will receive additional communication from a claims adjuster in relation to your injury at that time. If you have questions, please contact EMPLOYERS at 888-682-6671.

- If you remain under the care of an out-of-network provider and subsequently request a change of provider, you must receive approval to change providers and choose a new provider from the EMP KY MHCP network. You may locate an EMP KY MHCP physician by visiting the website, by calling the toll-free number or by contacting your claims adjuster.

- If you would like to remain under the care of an out-of-network provider, it is important to note that your provider is still subject to the EMP KY MHCP treatment and utilization standards. The provider must comply with utilization review, reporting standards, and quality assurance mechanisms required by the state of Kentucky and prescribed by the EMP KY MHCP.

- While participating in the EMP KY MHCP, EMPLOYERS may identify your case as benefiting from active case management. If your case is identified as such, a certified EMP KY MHCP case manager will keep track of your care and identify opportunities for cost-effective, alternative care and treatment with the goal of returning you to the work force or reaching Maximum Medical Improvement (MMI) as soon as possible. The case manager will coordinate the delivery of health services and return to work policies; promote an appropriate, prompt return to work; and facilitate communication between you, your employer, and your health care providers.

- You have the right to file a grievance if you are dissatisfied with the service provided to you within the EMP KY MHCP. A grievance is made when a written complaint or written request is delivered by the employee or provider to the EMP KY MHCP setting forth the nature of the complaint and remedial action requested. The employee or provider shall file a grievance within thirty (30) days of the occurrence of the event giving rise to the dispute. The EMP KY MHCP shall render a written decision upon a grievance within thirty (30) days of receiving the grievance. Any employee or provider dissatisfied with EMP KY MHCP's resolution of a grievance may apply for review by an Administrative Law Judge by filing a request for resolution within thirty (30) days of the date of EMP KY MHCP's final decision. Request for resolution should be submitted to the following:

  Kentucky Department of Workers' Claims
  657 Chamberlin Avenue
  Frankfort, KY 40601
  Phone: 502-564-5550

  Written grievances should be sent to Coventry at the following address: Coventry Grievance Coordinator, 3200 Highland Ave., Downers Grove, IL 60515.

An overview of the Grievance Process and a copy of the Grievance Form are attached. When completing the form, please describe your complaint in detail and the action you are requesting.

If at any time you would like additional information on the grievance process, please contact Coventry at 800-262-6122.

If you have further questions about the EMP KY MHCP or need help accessing medical treatment, please contact your claims adjuster at 888-682-6671.

Sincerely,

Claims Adjuster Signature
Claims Adjuster Name
Claims Adjuster Title
Claims Adjuster Phone
Fax: 866-461-2934

Enclosures: Verification of Coverage, Designated Physician Form 113, Initial Provider Letter, Medical Waiver Form 106 and Grievance Form.

cc: Worker's Representative
The Medical Provider

America's small business insurance specialist®

EMPLOYERS
Kentucky Managed Health Care Plan
(EMP KY MHCP)
Verification of Coverage

Dear Injured Employee,

Insurer Name has selected to partner with Coventry Health Care Workers' Compensation, Inc. (Coventry) to provide medical services through EMPLOYERS Kentucky Managed Health Care Plan (EMP KY MHCP). The EMP KY MHCP is a certified plan that provides access to medical care for workers who have work-related injuries or illnesses. The role of the EMP KY MHCP is to ensure that medical and health care services you receive are provided in a timely and effective manner that is convenient for you, the injured employee.

To help you find a provider, contact your claims adjuster at 888-682-6671 or visit the provider locater website at www.employers.com and go to the *For Injured Workers* tab, select *Provider Locator* and then *Kentucky*.

Present the Verification of Coverage card below to the provider at every visit. Possession of the card shall not be construed as authorization for medical service or payment. This card provides important contact information.

Cut along lines and place in wallet

EMPLOYERS

Coventry Workers' Comp Services

EMP KY MHCP
800-937-6824 (select options 1, 1 and 1)

Supply this card to the provider at every visit.

Carrier: _____

Employer Name: _____

Employer Address: _____

Employer Phone: _____

Employee Name: _____

Employee ID: _____

Note: Possession of Verification of Coverage card is not to be construed as authorization for medical service or payment. §803KAR 25:110.

Form 113
Designation of Physician
Revised 03-12-03

Two-Sided Form

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
Claim No.

NOTICE OF DESIGNATED PHYSICIAN

EMPLOYEE: _____
Name

_____
Street Address$

_____ _____
City, State, Zip Telephone Number

_____ _____
Date of Birth Social Security Number

EMPLOYER AT TIME OF INJURY OR LAST EXPOSURE:

_____
Name

_____
Street Address

_____
City, State, Zip

NATURE OF INJURY OR OCCUPATIONAL DISEASE: _____

DATE OF INJURY OR LAST EXPOSURE: _____

FIRST DESIGNATED PHYSICIAN:

_____
Name

_____
Street Address

_____ (____)_____
City, State, Zip Telephone Number

Accepted by: _____

MEDICAL INFORMATION RELEASE: I hereby waive any privilege I may have to restrict the release of information or written material reasonably related to the work-related injury/disease for which I have sought treatment, and I consent to the release of this information or written material to the medical payment obligor, my employer, Special Fund, Uninsured Employers' Fund, or attorneys representing me or any of the parties named above.

_____ _____
Date Employee Signature

MEDICAL PAYMENT OBLIGOR:

_____
Name Of Obligor

_____
Representative

_____
Street Address

_____ (____)_____
City, State, Zip Telephone Number

Notice:

The Workers' Compensation Act requires the employer to pay for the medical services reasonably necessary for cure and relief from the effects of a workplace injury or disease.

The employee may choose the physician (including chiropractors, etc.) who treats him as "designated physician." The designated physician is responsible for the coordination of the employee's medical care and may refer the patient to consulting or treating physicians as required. Except in an emergency, all treatment must be performed by or on referral from the designated physician. The employee may not change his designated physician more than once without the medical payment obligor's consent.

This form identifies the designated physician and must be returned to the medical payment obligor within ten (10) days after treatment begins. An identification card will be provided to the employee, and that card should be presented when medical treatment is required.

Inquiries shall be made to the listed representative of the medical payment obligor.

This form is not advance authorization from the workers' compensation medical payment obligor for medical services.

EIG Services, Inc.
In California, dba
EIG Insurance Services

Initial Visit Provider Letter

Date

Physician Name
Physician Address
City, State, Zip

Re: Employee / Empleado: Employee First and Last Name

Employer / Empleador: Employer Name
Claim Number / Num de Reclamo: Claim Number
Date of Injury / Fecha de lesion: Date of Injury
Insurer / Aseguradora: Insurer Name

Dear Provider:

Employee First and Last Name is coming to you for an initial visit as an employee of Employer Name who is a participant in the EMPLOYERS Kentucky Managed Health Care Plan (EMP KY MHCP). The EMP KY MHCP works in combination with Employer Name's workers' compensation carrier, Insurer Name and Coventry Health Care Workers Compensation, Inc. (Coventry), a national managed care company. This letter will help explain your responsibilities under this plan.

UTILIZATION REVIEW & CASE MANAGEMENT
Please contact Coventry's Utilization & Case Management Services at 800-691-1115 when one of the following occurs:

- Hospitalization
- Anticipated Surgery
- Fracture of a Major Bone/Non-Union Fracture
- Physical Therapy Recommended
- Anticipated Disability in Excess of Seven Days
- Prior Disability, by History, of the Same Body Part
- Anticipated Permanent Disability
- Referral to a Provider
- Treatment Plan to Exceed Two weeks

DESIGNATED GATEKEEPER PHYSICIAN
If you have agreed to be the injured employee's designated "Gatekeeper Physician," you must sign Form 113 indicating your acceptance of this designation. The injured employee has been provided a Form 113 with letter. The form must be returned to Insurer Name within 10 days after you start

treatment. If the form is not completed and returned within this time frame, including of your signature, all benefits payable may be suspended.

REFERRALS
If the patient requires a referral to a specialist, please contact Coventry's Provider Services at 800-937-6824, select options 1, 1 and 1 for a list of approved providers within the EMP KY MHCP network.

CLAIMS
All claims for treatment must be submitted to the claims administrator on the appropriate form required by the state of Kentucky. Please submit all medical reports within the time frame required by applicable state law.

RETURN TO WORK THROUGH ALTERNATIVE OR MODIFIED DUTY
In the best interest of the employee, we often 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 the employee.

Should you have any questions regarding your participation in the network, how the EMP KY MHCP works or if you wish to file a grievance please refer to the Coventry Provider Reference Manual via www.coventrywcs.com or contact your Coventry Workers Comp Provider Services Representative at 800-937-6824, select options 1, 1, and 1.

Sincerely,

Claims Adjuster Signature
Claims Adjuster Name
Claims Adjuster Title
Claims Adjuster Phone

cc:

EMPLOYERS®
America's small business insurance specialist®

COVENTRY
Workers' Comp Services

Coventry
Grievance Form
(Please **PRINT** Clearly)

The written grievance must contain, at a minimum, sufficient information to allow the Grievance Coordinator to address the grievance and must be filed within thirty (30) days from the event giving rise to the grievance. Coventry will render a written decision upon a written grievance within thirty (30) days of receipt by Coventry. In the unlikely event the individual filing the grievance remains dissatisfied with the resolution, they may file a written request for resolution within 30 days of the date of our final decision to an Administrative Law Judge. This written request should be sent to the Kentucky Department of Workers' Claims, 657 Chamberlin Avenue, Frankfort, KY 40601.

DATE:	**INITIATOR'S NAME:**	**INITIATOR'S PHONE #:** ( )
CLIENT NAME:		**EMPLOYER NAME:**
INJURED WORKER'S NAME (FIRST, M, LAST):	**DATE OF INJURY:**	**SSN#:**
PROVIDER NAME (FIRST, M, LAST or Facility Name):	**PROVIDER TITLE:**	**PROVIDER PHONE #:** ( )
PROVIDER OR FACILITY ADDRESS (Street, City, State and Zip):		
PROVIDER OR FACILITY TAX ID #:	**DATE OF DISSATISFACTION:**	

Please describe your complaint in detail below. Include dates, names, and the specific resolutions which you feel might remedy the situation. **PLEASE ATTACH COPIES OF APPLICABLE MEDICAL RECORDS TO THIS FORM.**

THIS ISSUE INVOLVES: **Service** _____ **Medical Care** _____ **Other** _____

_____

_____

_____

REQUESTED ACTION:

_____

_____

SIGNATURE:

FORWARD FORM TO: COVENTRY COMPLAINTS & GRIEVANCES, 3200 HIGHLAND AVE, DOWNERS GROVE, IL 60515
E-mail: complaintsandgrievances@cvty.com
Phone Number: 800-262-6122

OPTUM®

PO Box 152539
Tampa, FL 33684-2539

EMPLOYERS®
America's small business insurance specialist®

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

OPTUM®

EMPLOYERS®
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		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.*

tmesys®

IMP14-2013-84

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PO Box 152539
Tampa, FL 33684-2539

EMPLOYERS®
America's small business insurance specialist®

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

OPTUM®

EMPLOYERS®
America's small business insurance specialist®

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.*

tmesys®