



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:	

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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:	

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# 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.<sup>1</sup>

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](mailto:fraudfighters@employers.com).**

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<sup>1</sup> 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.<sup>1</sup>

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](mailto:fraudfighters@employers.com).**

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



**TENNESSEE BUREAU OF WORKERS' COMPENSATION  
EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS**

CLAIMS ADM/CARRIER	JURISDICTION CLAIM # (STATE FILE #)		CLAIM TYPE CODE <input type="checkbox"/> MED ONLY <input type="checkbox"/> INDEMNITY <input type="checkbox"/> BECAME LOST TIME <input type="checkbox"/> BECAME MED ONLY <input type="checkbox"/> NOTIFY ONLY <input type="checkbox"/> TRANSFER		<p>THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE TENNESSEE WORKERS' COMPENSATION LAW AND MUST BE COMPLETED AND FILED WITH YOUR INSURANCE CARRIER IMMEDIATELY AFTER NOTICE OF INJURY.</p> <p>IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS' COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.</p> <p>IF YOU HAVE QUESTIONS, THE STATE NOW HAS A BENEFIT REVIEW SYSTEM WHERE A WORKERS' COMPENSATION SPECIALIST CAN PROVIDE ASSISTANCE. CALL 1-800-332-2667 (TDD).</p>					
	CLAIMS ADM CLAIM # (INSURER CLAIM #)		CARRIER FEIN							
	OSHA LOG CASE #		FEIN OF CLMS ADM							
	NAME OF INSURANCE CARRIER		CLMS ADJ PHONE #							
	CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)		CITY					STATE	ZIP	
	CLAIMS ADJUSTER NAME		CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2							
EMPLOYER	EMPLOYER NAME		EMPLOYER FEIN		SIC CODE		PHONE NUMBER			
	EMPLOYER ADDRESS LINE 1 AND LINE 2				NATURE OF BUSINESS					
	CITY		STATE	ZIP	INSURED REPORT #		EMPLOYER LOCATION			
POLICY	INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)		POLICY NUMBER		EFF DATE		<b>EMPLOYMENT STATUS CODE</b> <input type="checkbox"/> FULL TIME/REGULAR <input type="checkbox"/> PART TIME <input type="checkbox"/> PIECE WORKER <input type="checkbox"/> SEASONAL <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> APPRENTICE FULL TIME <input type="checkbox"/> APPRENTICE PART TIME			
			SELF INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO		EXP DATE					
EMPLOYEE	EMPLOYEE LAST NAME		PHONE INCL AREA CODE		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN					
	FIRST	MI	DEPARTMENT REGULARLY WORKED		OCCUPATION DESCRIPTION					
	ADDRESS LINE 1 & 2		CITY		STATE	ZIP	MARITAL STATUS <input type="checkbox"/> UNMARRIED, SINGLE, DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN		NCCI CLASS CODE	
	SSN		DATE OF BIRTH	DATE OF HIRE						
	WAGE \$		PERIOD <input type="checkbox"/> WEEKLY <input type="checkbox"/> HOURLY <input type="checkbox"/> DAILY	NUMBER OF DAYS WORKED PER WEEK		SALARY CONTINUED IN LIEU OF COMPENSATION <input type="checkbox"/> YES <input type="checkbox"/> NO				
						FULL WAGES PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO				
ACCIDENT/INJURY	DATE OF INJURY		TIME OF INJURY <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> COULD NOT BE DETERMINED		TIME EMPLOYEE BEGAN WORK ON INJURY DATE <input type="checkbox"/> AM <input type="checkbox"/> PM					
	DATE EMPLOYER NOTIFIED OF INJURY		BODY PART AFFECTED CODE		NATURE OF INJURY CODE		CAUSE OF INJURY CODE			
	DATE CLAIM ADM NOTIFIED OF INJURY		HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE INCIDENT INCLUDING WHAT THE EMPLOYEE WAS DOING JUST BEFORE, THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY HARMED THE EMPLOYEE.							
	DATE LAST DAY WORKED									
	DATE DISABILITY BEGAN									
	RETURN TO WORK DATE (IF APPLICABLE)									
	DATE OF DEATH (IF APPLICABLE)		IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP <input type="checkbox"/> WIDOW <input type="checkbox"/> FATHER                      _____ SISTER                      TOTAL # DEPENDENTS <input type="checkbox"/> WIDOWER                      _____ DAUGHTER                      _____ BROTHER <input type="checkbox"/> MOTHER                      _____ SON                      _____ HANDICAPPED CHILD							
	DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO									
ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)							COUNTY OF INJURY			
		CITY		STATE	ZIP					
TREATMENT	PHYSICIAN NAME			HOSPITAL OR OFF SITE TREATMENT NAME						
	ADDRESS LINE 1 AND 2			ADDRESS LINE 1 AND 2						
	CITY		STATE	ZIP	CITY		STATE	ZIP		
	INITIAL TREATMENT <input type="checkbox"/> NO MEDICAL TREATMENT		<input type="checkbox"/> MINOR BY EMPLOYER <input type="checkbox"/> MINOR BY CLINIC/HOSPITAL		<input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> EMERGENCY CARE		<input type="checkbox"/> FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED			
OTHER	DATE PREPARED		PREPARER'S NAME & TITLE		PREPARER'S COMPANY NAME		PHONE NUMBER			



**Employer**

- List at least three physicians and provide this panel to employee upon the report of a workplace injury.
- Keep the completed original form on file and send a copy to the employee for their records.
  - Do *not* send this form to the State unless requested.

**Employee**

- Fill out the bottom portion of this form to indicate which physician you choose.
  - If you refuse to accept medical services from the chosen physician, your rights to benefits may be delayed.
  - Traveling more than 15 miles (one way) to (or from) medical treatment? Employees may seek reimbursement of their travel expenses from the insurance carrier.
- **Send** completed form **back to your employer**.

**TO BE COMPLETED BY THE EMPLOYER:**

Employee Name \_\_\_\_\_ Date Panel Provided \_\_\_\_\_

Employer \_\_\_\_\_ Date of Injury \_\_\_\_\_

Employer Contact \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

Physician 1	Physician 2	Physician 3
Name _____	Name _____	Name _____
Phone _____	Phone _____	Phone _____
Address _____ _____	Address _____ _____	Address _____ _____
City _____	City _____	City _____
State _____ Zip _____	State _____ Zip _____	State _____ Zip _____
Is Telehealth available with Physician #1? Yes ___ No ___	Is Telehealth available with Physician #2? Yes ___ No ___	Is Telehealth available with Physician #3? Yes ___ No ___
If yes, web address _____	If yes, web address _____	If yes, web address _____
(Optional) Telehealth-Only <b>Physician 4</b> Name _____ Phone _____ Telehealth Provider email address _____ Web address _____		

**TO BE COMPLETED BY THE EMPLOYEE:**

**I have selected the following physician from the list provided to me by my employer:**

Physician Name \_\_\_\_\_ Appt Date/Time \_\_\_\_\_

I select: In-person treatment \_\_\_ **or** Treatment by Telehealth \_\_\_ Were you offered in-person treatment? Yes \_\_\_ No \_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_



## 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<sup>®</sup> 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](http://tmesys.com).



### Questions? Need Help?

# 1-866-599-5426

 	
<b>WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM</b>	
CARRIER/TPA	EMPLOYER
INJURED PERSON NAME	
Please provide directly to Pharmacist	
SOCIAL SECURITY NUMBER	DATE OF INJURY (YYMMDD)
<b>Notice to Cardholder:</b> Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: <a href="http://tmesys.com">tmesys.com</a> .	

**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		002538
RxPCN	CAL		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<sup>®</sup>. 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](http://tmesys.com).



### ¿Tiene alguna pregunta? ¿Necesita ayuda?

# 1-866-599-5426




America's small business insurance specialist<sup>®</sup>

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

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](http://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.



# TENNESSEE WORKERS' COMPENSATION INSURANCE POSTING NOTICE

## How to Report Work-Related Injuries

*What should be done if injured at work?*

### Employee

1. Immediately **report the injury** to the employer representative named below.
2. **Select a treating physician** from a panel provided by your employer.
3. If you have questions or problems, contact the employer representative or the Bureau of Workers' Compensation.

### Employer

1. Complete your company's internal "Workplace Injury form" and **notify your workers' compensation insurance company** immediately, even if you have concerns about the validity of the claim.
2. **Offer a panel of physicians** to the employee via Form C-42 available on the Bureau's website. *In cases of emergency, call an ambulance and provide this form as soon as the injured employee has stabilized.*

\_\_\_\_\_  
*Printed **name and title** of the employer representative to be notified in the event of a work-related injury*

\_\_\_\_\_  
*Printed name of an **alternative employer representative** to be notified in the event of a work-related injury*

\_\_\_\_\_  
***Telephone number** of employer representative to notify in event of a work-related injury*

\_\_\_\_\_  
***Address** of employer representative to notify in event of a work-related injury*

The Tennessee Bureau of Workers' Compensation is available to help both employees and employers.



220 French Landing Dr. 1-B  
Nashville, TN 37243-2667  
**800-332-2667**  
615-532-4812 TTD: 800-332-2257  
[tn.gov/workerscomp](http://tn.gov/workerscomp)

*Workers' Compensation law requires this notice to be posted in a conspicuous place at the work site at all times.*



Tennessee Bureau of Workers' Compensation  
220 French Landing Drive, I-B  
Nashville, TN 37243-1002

FORM C-41

WAGE STATEMENT

EMPLOYEE: \_\_\_\_\_ SSN: \_\_\_\_\_ STATE FILE #: \_\_\_\_\_

Employer \_\_\_\_\_ Ins Claim # \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Please list the wages earned by the employee named above during each of the 52 weeks prior to date of injury, if applicable.

WEEK	WEEK ENDING	GROSS WAGES	WEEK	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		
				TOTAL PAID	

Date: \_\_\_\_\_ Name of Preparer and Title \_\_\_\_\_

# SEGURO DE COMPENSACIÓN A TRABAJADORES DE TENNESSEE

# PUBLICACIÓN DE AVISO

## Cómo informar de lesiones laborales

*¿Qué se debe hacer en caso de lesión laboral?*

### Empleado

1. **Informe** inmediatamente de **la lesión** al representante del empleador indicado aquí abajo.
2. **Seleccione un médico tratante** del panel provisto por su empleador.
3. Si tiene alguna pregunta o problema, comuníquese con el representante de empleadores de la Oficina de Compensación a Trabajadores.

### Empleador

1. Complete el formulario interno de su empresa de "Lesión laboral" y **notifique a su aseguradora de compensación a trabajadores** inmediatamente, incluso aunque tenga dudas acerca de la validez de la reclamación.
2. **Ofrezca un panel de médicos** al empleado a través del Formulario C-42, disponible en el sitio web de la Agencia. *En casos de emergencia, llame a una ambulancia y proporcione este formulario en cuanto el empleado lesionado se haya estabilizado.*

\_\_\_\_\_  
*Nombre en letra de molde y título del representante del empleador a ser notificado en caso de una lesión laboral*

\_\_\_\_\_  
*Nombre en letra de molde del representante del empleador alternativo a ser notificado en caso de una lesión laboral*

\_\_\_\_\_  
*Número de teléfono del representante del empleador a ser notificado en caso de una lesión laboral*

\_\_\_\_\_  
*Dirección del representante del empleador a ser notificado en caso de una lesión laboral*

La Oficina de Compensación a Trabajadores de Tennessee está disponible para ayudar a empleados y empleadores.



220 French Landing Dr. 1-B  
Nashville, TN 37243-2667  
**800-332-2667**  
615-532-4812 TTD: 800-332-2257  
[tn.gov/workerscomp](http://tn.gov/workerscomp)

*La ley de Compensación a Trabajadores exige que se publique este aviso en un lugar visible en el centro de trabajo en todo momento.*