



WORKER INJURY ON-THE-JOB?

Life-threatening or Emergency: Call 911 immediately

1. Employee needs to be treated at the **closest emergency room**
2. If possible, **send** a printed copy of:
 - ✓ **FORM 1:** Treatment Authorization Form
 - ✓ **FORM 2:** Optum Pharmacy Prescription Form
 - ✓ **FORM 3:** LabCorp Post-Accident Drug Testing Form
3. **Notify Fourth immediately** - fill out and email or fax **Form 4 (First Notice of Injury)**
 - The injury may be reportable to OSHA or your state. Ask Fourth for guidance.

NON-EMERGENCY:

Send Employee to closest Urgent Care, Walk-in Clinic, or ER for Treatment

1. Send printed copy of:
 - ✓ **FORM 1:** Treatment Authorization Form (**use website on form to find treatment locations**)
 - ✓ **FORM 2:** Optum Pharmacy Prescription Form
 - ✓ **FORM 3:** LabCorp Post-Accident Drug Testing Form
2. **Notify Fourth immediately** - fill out and email or fax **Form 4 (First Notice of Injury)**
 - The injury may be reportable to OSHA or your state. Ask Fourth for guidance.

All forms are included in this packet and are also available online at <https://www.fourth.com/hr-form-center/> under the Workers' Compensation Forms section. You can also call Fourth at **813-643-4000** or **877-315-0004** if you have any additional questions.

FORM 1: Treatment Authorization Form - Provide this form to their treatment facility; it contains needed billing and policy information. There is also a website <http://www.talispoint.com/amtrust/external/> on the form to locate treatment facilities such as walk-in clinics, urgent care facilities, and emergency rooms. You can also call Fourth at 813-643-4000 during normal business hours.

FORM 2: Optum Pharmacy Prescription Form - Please fill in the employee's name and date of injury. The injured employee will need to provide this form to the network pharmacy if the treating physician prescribes medication for the work-related injury. This form contains the needed billing and policy information so that the prescription is not an out-of-pocket cost.

FORM 3: LabCorp Post-Accident Drug Testing Form - Provide the injured employee with the **LabCorp Form** and direct the employee to report to the nearest LabCorp facility with a picture ID **as soon as reasonably possible**. A drug and alcohol test are required even if no treatment / medical attention will be sought. Employees can visit www.labcorp.com or call 1-800-329-6334 and select option 4 to locate a collection site.

FORM 4: First Notice of Injury Report - Fill out the **First Notice of Injury Report** and email it to: wclaims@fourth.com or fax (813) 643-4441 it to Fourth. Instructions are included on the form. This form must be completed in its entirety, although don't delay reporting for any reason.

FORM 5: Refusal of Treatment Form - Should the injured employee decide to refuse treatment/medical attention, complete and return **both FORM 4 & 5 (First Notice of Injury Form and the Refusal of Treatment Form)**. The employee will also be required sign the forms; if the injured employee refuses to complete and sign the form, a manager or authorized representative is to complete the Refusal of Treatment Form on behalf of the injured employee and make note of the employee's refusal to sign the document. This should be faxed along with the First Notice of Injury Report.

Form 1



Treatment Authorization Form

In the event of an employee injury, the employee should immediately notify a member of Management and follow the steps listed on the first page.

If medical treatment is needed, the injured employee will need to provide the following information to the Network Provider.

Local Network Providers can be obtained by going online to:
<http://www.talispoint.com/amtrust/external/>

You can also call Fourth at **813-643-4000** during normal business hours.

Insured: Fourth

Insurer: AmTrust North America (Technology Ins. Co.)

Please Fax DWC-25 Form to: 813-643-4441

Billing Information:

AmTrust North America
PO Box 94574
Cleveland, OH 44101
Phone: 1-800-866-8600

DRUG TEST is Required within 24 Hours of Injury

Employers are required to submit all claims to FOURTH within a 24-hour period.

Form 2



LABCORP WEB COC FORENSIC DRUG-FREE WORKPLACE COLLECTION AUTHORIZATION FORM

Donor Name: _____

Donor must bring this Authorization Form and Photo ID to the collection site.

Specific account information for collection services for this donor:

ASAP/ Fourth

LabCorp Account #: 514581

Location Code: None Required

Test(s) To Be Performed: Employer please check the following:

Choose Reason for Test:

- | | |
|---|------------------------------------|
| <input type="checkbox"/> Pre-employment | <input type="checkbox"/> Random |
| <input type="checkbox"/> Return to Duty | <input type="checkbox"/> Follow-up |
| <input checked="" type="checkbox"/> Accident | <input type="checkbox"/> Other |
| <input type="checkbox"/> Reasonable Suspicion/Cause | |

Choose Testing Panel:

- | |
|--|
| <input type="checkbox"/> Profile 1 - 5 Panel |
| <input type="checkbox"/> Profile 2 - 8 Panel |
| <input checked="" type="checkbox"/> Profile 3 - 10 Panel |

EMPLOYER/DONOR:

To locate a LabCorp collection site location, go to **www.labcorp.com**, click on the "Labs & Appointments" box, enter your address or zip code, then choose "Employment Drug Testing" as the service and click "Go". A list of collection locations will display along with addresses, hours of operation, and the ability to schedule an appointment.

If you have any questions, please call 800-329-6334 Option 4

Form 3

Pharmacy Prescription Card



Optum
PO Box 152539
Tampa, FL 33684-2539



AmTrust North America
An AmTrust Financial Company

MAKING IT EASY... TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:



If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.



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



Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?



1-866-599-5426

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
CARRIER/TPA _____ EMPLOYER _____

INJURED WORKER NAME _____

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER _____ DATE OF INJURY (YYMMDD) _____

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC	or	Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

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



Employer:

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

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc, dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."

tmesys®

IMP14-1614-109-FFWG



FORM 4

First Notice of Injury

Please notify Fourth **immediately after the workplace injury** by emailing or faxing this form to: **wcclaims@fourth.com** or **813-643-4441**. Do not delay reporting.

Client Name		Today's Date	
Employee Name		Employee SSN	
Date of Accident		Time of Accident	<input type="checkbox"/> AM <input type="checkbox"/> PM
Employee Address		Phone Number	
City, State, Zip		Date of Birth	
Occupation		Date of Hire	

Accident Information (to be completed by a supervisor)

Supervisor's Name:		Supervisor's Contact Number:	
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Employee's Description of Accident: _____

Part of Body Injured (including left or right side):	
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Injury or Illness that occurred?	
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Did accident occur on premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "no", where?
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Equipment or devices damaged? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "yes", what?
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Were there any witnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "yes", list names:
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Was the employee wearing: <input type="checkbox"/> slip resistant/safety shoes <input type="checkbox"/> cut-resistant gloves <input type="checkbox"/> chemical-resistant gloves <input type="checkbox"/> eye protection <input type="checkbox"/> rubber apron <input type="checkbox"/> hearing protection <input type="checkbox"/> respiratory protection <input type="checkbox"/> other:

Do you agree with the description of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no", reason? _____
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Facility Name, Address, and Phone Number where employee sought treatment:	_____ _____ _____
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Was the employee sent for drug test? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "yes", facility name: _____ Address: _____ Phone: _____
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Do you know of any other prior accidents or pre-existing conditions that may have been a factor in this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", explain: _____ _____
--

Has employee returned to work? <input type="checkbox"/> Yes - Date? _____ <input type="checkbox"/> No - Last date worked? _____
--

Will you continue to pay wages instead of workers' comp? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", through when? _____

Employee's current wage? \$ _____ Per? _____
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Average hours per day? _____	Average hours per week? _____	Average number of days per week? _____
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Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits fraud, punishable as provided in s.817.234. Section 441.105(7), F.S.

I have reviewed, understand and acknowledge the above statement.

Employee Signature (if applicable): _____ **Date:** _____

Employer Signature: _____ **Date:** _____

Form 5



Refusal of Treatment Form

Client Name: _____

Employee Name: _____

Date of Injury: _____

Description of Accident: _____

To be completed by employee

Reason I am declining medical treatment: _____

I understand that medical treatment is available to me paid for by Fourth (employer) for the accident described above. I confirm that _____ offered me this medical treatment on _____ for this work-related accident. By my own choice, I have decided NOT to seek medical treatment for this injury. Should I seek medical treatment at a later date for this work-related injury, I must first contact my employer and receive authorization PRIOR to being treated. I also understand that to receive this employer paid medical treatment for this injury; I must go to the approved medical provider that my employer provides and also complete all necessary paperwork for an authorization from my employer. Any treatment I receive before an authorization has been granted will result in non-payment by my employer.

Employee Printed Name

Date

Employee Signature

Date

Signature of Witness

Date