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:** LabCorp Post-Accident Drug Testing Form
   - ✓ **FORM 3:** Zurich Medical Information form with pharmacies
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:** LabCorp Post-Accident Drug Testing Form
   - ✓ **FORM 3:** Zurich Medical Information form with pharmacies
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/support/hr-form-center under the Workers' Comp 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.goperspectra.com/VPD/zurich** 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: 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 3: Zurich Medical Information Guide - Please fill in the employee's name, date of injury and state. It provides the injured employee with contact information for finding providers, scheduling services, medical equipment, home health, transportation, diagnostic imaging, and information how to submit medical bills. Network pharmacies are also listed if the treating physician prescribes medication for the work-related injury so that the prescription is not an out-of-pocket cost.

FORM 4: First Notice of Injury Report - Fill out the **First Notice of Injury Report** and email it to: **wcclaims@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.

Find Treatment Providers

Zurich - Find a Provider (https://www.goperspecta.com/VPD/zurich)

	Online source of medical providers who specialize in treating workers compensation injuries and illnesses as well as provider reviews and outcome ratings. Go to the website by using the web address above, QR code, or call **866-732-5342**.

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

The injured employee will need to provide the following information to the network provider.

Insured: Choice Employer Solutions Inc. dba: Fourth HR / Employer Name: _____

Insurer: Zurich North America

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

Billing Information:

Submit Claim Related Documents Online: www.zurichna.com/claims → "upload documents"	**E-billing:** Electronic Clearinghouse – Jopari Solutions (Payer ID: Zurich Insurance N.A. - 16535)
Email: usz.zurich.claims.documents@zurichna.com	**Fax:** 847-240-8172
Mail: Zurich North America – Claims P.O. Box 968070 Schaumburg, IL 60196-8070	**Medical Provider Helpline:** 719-590-8719

∗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

ASAP™ Powered by: Applicant 360®
Drug-Free Workplace & Background Screening Solutions

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/ Choice Employer Solutions, Inc. dba Fourth HR

LabCorp Account #: 514581

Location Code: None Required

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

Choose Reason for Test:

[ ] Pre-employment [ ] Random
[ ] Return to Duty [ ] Follow-up
[X] Accident [ ] Other
[ ] Reasonable Suspicion/Cause

Choose Testing Panel:

[ ] Profile 1 - 5 Panel
[ ] Profile 2 - 8 Panel
[X] 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

Workers' Compensation medical information guide

ZURICH

We hope you find this resource helpful in navigating your Workers' Compensation coverage for your work-related illness or injury so that you can get the care you need. If you have questions or need additional information, call us at 800-987-3373.

EMPLOYEE INFORMATION

CLAIMANT NAME:

CLAIM NUMBER:

DATE OF INJURY:

STATE:

Note: Modified duty may be available, contact your employer for details.

SCHEDULING SERVICES

If your doctor requires you to have any of the following services/treatments, scheduling can be provided by calling the following:

Medical Equipment, Home Health, Transportation and Translation: Healthe Systems 844-402-1842

Diagnostic Imaging (e.g., MRI, CT):
CareWorks 866-535-0905
Navigere 800-595-7173
One Call 800-490-1909

PHARMACY INFORMATION

If you need a prescription filled for your work-related injury or illness, for your convenience, you can go to an Optum Tmesys network pharmacy. Please give this temporary card to the pharmacist. When the pharmacy is part of the Optum Tmesys network, the pharmacist will fill your prescription at no cost to you. If your pharmacy is not part of this network, you may need to pay for the prescription and seek reimbursement from the carrier.

	NDC	Envoy
BIN	004261	002538
CVPCN	CAL	Account#
FF Group	ZRCHFF	NA

Participating Pharmacies

Costco	Target
CVS	Walgreens
Sam's Club	Walmart

Pharmacy Help Line: 800-964-2531

For additional participating pharmacies in your area, go to www.tmesys.com or call 866-599-5426.

BILLING INFORMATION

Send medical bills to:

Submit Claim-Related Documents Online:
www.zurichna.com/claims
"Upload Documents"

E-billing: Electronic clearinghouse - Jopari Solutions (Payer ID: Zurich Insurance N.A. -16535)

Email: usz.zurich.claims.documents@zurichna.com

Fax: 847-240-8172

Mail:
Zurich North America - Claims
P.O. Box 968070
Schaumburg, II 60196-8070

Medical Provider Helpline: 719-590-8719

C.A.R.E. ® Directory

Online source of medical providers who specialize in treating Worker's Compensation injuries and illnesses as well as provider reviews and outcome ratings. Go to www.goperspecta.com/vpd/zurich or call 866-732-5342.

Zurich
1299 Zurich Way, Schaumburg, IL 60196-1056
800 982 5964 www.zurichna.com

Guia de informaci6n medica de compensaci6n de trabajadores

ZURICH

Esperamos que este recurso le sea util mientras navega por la cobertura de compensaci6n de trabajadores correspondiente a su lesion o enfermedad de origen laboral, de modo que pueda recibir la atenci6n que necesita. Si tiene alguna consulta o necesita informaci6n adicional, llamenos al 800-987-3373.

INFORMACIÓN DEL EMPLEADO

NOMBRE DEL SOLICITANTE:

NUMERO DE RECLAMO:

FECHA DE LA LESION:

ESTADO:

Nata: El trabajo modificado podria estar disponible,. comuniquese con su empleador para obtener mas informaci6n.

PROGRAMACIÓN DE SERVICIOS

Si su medico requiere que usted reciba cualquiera de las siguientes servicios o tratamientos, llame a las siguientes numeros para programarlos:

Equipo medico, atenci6n medica domiciliaria, transporte y traslado: Healthe Systems 844-402-1842

Imagenologia diagn6stica (p. ej., IRM o TC):
CareWorks 866-535-0905
Navigere 800-595-7173
One Call 866-490-1909

INFORMACIÓN FARMACÉUTICA

Para su conveniencia, usted puede ir a una farmacia de la red de Optum Tmesys si tiene que adquirir un medicamento con prescripci6n para su lesion o enfermedad relacionada con el trabajo. Par favor dele esta tarjeta temporal al farmaceutico. Cuando la farmacia forme parte de la red e Optum Tmesys, el farmaceutico le proporcionara su medicamento con prescripci6n sin costo alguno para usted. Si su farmacia no forma parte de esta red, es posible que usted tenga que pagar al medicamento con prescripci6n y solicitar el reembolso a la compania de seguros.

	NDC	Envoy
BIN	004261	002538
CVPCN	CAL	N.º de cuenta
GRUPO FF	ZRCHFF	NA

Linea de ayuda farmaceutica: 800-964-2531

Para mas informaci6n sabre las farmacias en su area, visite www.tmesys.com o llame al 866-599-5426.

INFORMACIÓN DE FACTURACIÓN

Envie las cuentas medicas a
(send medical bills to):

Online: www.zurichna.com/claims

E-billing: Electronic clearinghouse- Jopari Solutions
(Payer ID: Zurich Insurance N.A.-16535)

Email: usz.zurich.claims.documents@zurichna.com

Fax: 847-240-8172

Mail:
Zurich North America - Claims (Solicitudes)
P.O. Box 968070
Schaumburg, IL 60196-8070

Linea de ayuda del proveedor: 719-590-8719

Directorio de C.A.R.E. ®

Una fuente en linea de proveedores de atenci6n medica especializados en brindar tratamiento de lesiones y enfermedades de! programa de compensaci6n de trabajadores asi coma de evaluar proveedores y resultados. Visite www.goperspecta.com/vpd/zurich o llame al 866-732-5342.

Zurich
1299 Zurich Way, Schaumburg, IL 60196-1056
800 982 5964 www.zurichna.com

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**	☐**AM** ☐**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:	

Employee's Description of Accident: _____

_____

_____

Part of Body Injured (including left or right side):	
Injury or Illness that occurred?	
Did accident occur on premises? ☐ Yes ☐ No	If "**no**", where?
Equipment or devices damaged? ☐ Yes ☐ No	If "**yes**", what?
Were there any witnesses? ☐ Yes ☐ No	If "**yes**", list names:

Was the employee wearing: ☐ slip resistant/safety shoes ☐ cut-resistant gloves ☐ chemical-resistant gloves ☐ eye protection ☐ rubber apron ☐ hearing protection ☐ respiratory protection ☐ other:

Do you agree with the description of the accident? ☐ Yes ☐ No If "**no**", reason? _____

Facility Name, Address, and Phone Number where employee sought treatment:	_____ _____ _____
Was the employee sent for drug test? ☐ Yes ☐ No	If "**yes**", facility name: _____ Address: _____ Phone: _____

Do you know of any other prior accidents or pre-existing conditions that may have been a factor in this accident? ☐ Yes ☐ No If "**yes**", explain: _____

_____

Has employee returned to work? ☐ Yes - Date? ☐ No - Last date worked?

Will you continue to pay wages instead of workers' comp? ☐ Yes ☐ No If "**yes**", through when?

Employee's current wage? $ Per?

Average hours per day?	Average hours per week?	Average number of days per week?

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