



## Claims Reporting

### Policy and Procedures

### West Virginia

Fax or email all completed forms **WITHIN 4 HOURS** of notification of an injury to:

239-415-1114

Or

[claim@continuumhr.com](mailto:claim@continuumhr.com)

March 2018

# OSHA –REPORTING REQUIREMENTS

OSHA requires the reporting of severe work-related injuries and illnesses that all covered employers must adhere. All fatalities must be reported within 8 hours and all inpatient hospitalizations, amputations and loss of an eye within 24 hours to OSHA.

## How to report fatalities, severe work-related injuries, and illnesses to OSHA?

You can report to OSHA by:

- Calling OSHA's free and confidential number at 1-800-321-OSHA (6742)
- Calling your closest OSHA Area Office during normal business hours
- Using the new OSHA online form found at:  
<https://www.osha.gov/pls/ser/serform.html>

## Information Required When Filing a Report

- Establishment name
- Location of the incident
- Time of the incident
- Type of reportable event
- Number of employees injured / deceased
- Names of injured / deceased
- Your contact person and phone number
- Description of incident

Only fatalities occurring within 30 days of the work-related incident must be reported to OSHA. Further, for an inpatient hospitalization, amputation or loss of an eye, these incidents must be reported to OSHA only if they occur within 24 hours of the work-related incident.

Because of the time restraints, **YOU**, the on-site employer should notify OSHA of all reportable events using one of the methods described above. If however, you notify CHR in time and with **ALL** of the required information, we would be happy to assist you by notifying OSHA on your behalf. When calling CHR for assistance in this matter, please be clear in stating that you wish CHR to contact OSHA to report the accident.

Should you have any questions, please feel free to contact the office @239-415-1110 or [claim@ContinuumHR.com](mailto:claim@ContinuumHR.com).



## Post Accident Drug Testing

Post accident drug testing is a requirement of your insurance carrier. **In ALL CASES where an employee receives initial medical treatment for a workplace accident, a post accident drug test is REQUIRED.** Drug testing should be performed the same day of treatment or prior to reporting to work the following day. In almost all cases, a drug test is required within **4 hours, but no later than 24 hours** of the initial incident or of the employee reporting the incident.

We have made this process easier for you by establishing accounts at Labcorp and Quest Diagnostics. By taking the applicable Chain of Custody (COC) form to the location, the employee can be tested and returned to work as quickly as possible and at no cost to you or the employee.

In addition, some Walk-In Clinics perform post accident testing at their facility. If possible, check with the facility prior to sending the employee and see if they use either Labcorp or Quest for testing. If they do, when the employee goes for initial treatment, make sure they bring the appropriate COC. That way, the employee can receive the initial treatment and submit the drug test in the same visit.

**It is of the utmost importance that the employee be drug tested within 4 hours, but no later than 24 hours.**

While we ask when possible to use a Labcorp or Quest for post accident testing, as long as an accredited lab conducts the test, it will meet your obligation to the carrier.

If your clinic does not use Labcorp or Quest, you can find your nearest lab locations by using the links below. Pay special attention to the times drug testing is offered at each location as it may differ from lab to lab.

### LabCorp

<https://www.labcorp.com/wps/portal/findalab>

### Quest

<https://secure.questdiagnostics.com/hcp/psc/jsp/SearchLocation.do?newSearch=FindLocation>

If you have not received your Chain Of Custody forms or need more, please call our office at 239-415-1110 and we will order more for you.

Please note; the COC's you receive are ONLY to be used for post accident testing. All other types of drug tests (pre-hire, random, etc.) are coordinated using the Global HR online system. Please contact our HR Department for further information regarding that process.



## Claims Reporting Forms and Procedures

All forms and medical paperwork are to be faxed or emailed to the Claims Center at 239-415-1114 or [claim@continuumhr.com](mailto:claim@continuumhr.com)

<p style="text-align: center;"><b><u>First Report of Injury (FROI)</u></b></p>	<p>Complete this form IMMEDIATELY. Do not wait until other forms are completed. Submit to the Continuum HR Claims Center via email or fax <b><u>within 4 hours</u></b> of the accident. A sample form has been included as a reference. If an employee requires medical treatment, <b><u>YOU are required</u></b> to contact the clinic and arrange the first visit.</p>
<p style="text-align: center;"><b>AR-1</b> Employee Injury/Illness Accident Report</p>	<p>Form needs to be completed by the injured worker <b><u>ASAP</u></b> following an accident and basic first aid or medical treatment.</p>
<p style="text-align: center;"><b>AR-2</b> Supervisor's Accident Investigation Report</p>	<p>Form needs to be completed every time an employee is involved in a work related injury or accident. This form is also to be used for "Report Only" incidents that do not require medical attention. Form should be completed and submitted with the FROI within 4 hours of the accident. This form will assist the supervisor with conducting a thorough investigation</p>
<p style="text-align: center;"><b>AR-3</b> Witness Statement Form</p>	<p>Form needs to be completed whenever there is a witness to an accident. Have all witnesses complete this form immediately following the incident, while facts are clear. Once completed, the form should be signed and returned to the Claims Center via email or fax.</p>
<p style="text-align: center;"><b><u>Chain of Custody</u></b> Drug Test Form</p>	<p><b><u>Post Accident drug tests are mandatory and must be performed within 24 hours of the incident.</u></b> Send or escort the employee to the nearest Labcorp facility with the Labcorp Chain of Custody form. Labcorp locations can be found at <a href="https://www.labcorp.com/wps/portal/findalab">https://www.labcorp.com/wps/portal/findalab</a> CHR can schedule this appointment for you. Please call 239-415-1110 for assistance.</p>
<p style="text-align: center;"><b>AR-4</b> Consent for Release of Medical Information</p>	<p>Form needs to be completed and sent to CHR <b><u>if/when the employee seeks medical treatment.</u></b> This completed form proves our ability (CHR / the carrier) to request and receive medical documents relating to the claim directly from the treating facility.</p>
<p style="text-align: center;"><b>AR-5</b> Medical Authorization for Initial Treatment</p>	<p>Form should be sent with the injured employee to the medical provider. Fill in the employee's name and Social Security Number before employee seeks treatment.</p>
<p style="text-align: center;"><b>AR-6</b> Refusal of Medical Treatment</p>	<p>If an employee reports an incident but <b><u>refuses medical treatment</u></b>, have them complete this form <b><u>immediately</u></b>. This is not a waiver for all medical treatment. The employee may choose at a later date to seek medical treatment if necessary, however, they <b><u>MUST follow the state mandated guidelines</u></b> for Workers Compensation injuries. They <b><u>cannot</u></b> go to their personal physician or an ER without prior authorization from the Claims Center. A post accident drug screen <b><u>may/may not be required</u></b> when an employee signs this form. Please call CHR for guidance.</p>
<p style="text-align: center;"><b><u>Medical Treatment and Paperwork</u></b></p>	<p>After any and all medical treatment(s), employees are required to supply the employer with all paperwork provided by the treating physician(s). This paperwork must be faxed immediately to the claims center. The injured employee must <b><u>keep to all appointments</u></b>... even if they are feeling better.</p>



## **Workers Compensation FAQ**

**Should I send my injured employee to the Emergency Room?** Only use ER's for sever/traumatic injury cases, if it is after normal business hours and clinics are closed, OR, if a walk in clinic is not located within a reasonable distance of the employee. Treatment is typically slower in an ER and can **cost as much as 5 times more** than a clinic for most common workplace injuries.

**Should someone go to the clinic with my injured employee the first time?** If at all possible you should send a company representative to the clinic with the employee. This shows the employee that you care and ensures that you are aware of any developments or complications with the treatment.

**When an employee is injured, should I call the clinic?** YES! Contact the nearest clinic and let them know you have an employee on the way, the nature of the injury, and that it is a work comp claim. **This is a requirement in some states and is always a good practice.** Ensure that the clinic has the "Medical Authorization For Initial Treatment" (AR-5) form.

**Why do I have to forward the medical paperwork? Doesn't it come to your and the carrier anyway?** Eventually the paperwork may find its way to us and the carrier, however, it may be days or weeks after the treatment. By not forwarding your copies of the paperwork, you could possibly delay necessary treatments, specialist referrals, diagnostics, and increase the overall cost of the claim.

**What is "Light Duty"?** Light duty refers to tasks the employee has been medically approved to perform while they heal from their injury. Often times the treating physician does not allow the injured employee to perform his/her regular duties based on the physical demands of their original position. The doctor then states on a form what physical activities are allowed during the employees' recovery. The restriction may change after additional medical treatments so always refer to the most recent medical paperwork returned with the employee.

**If I have an employee that is taken out of work by the treating doctor, what should I do.** Notify us immediately and forward all medical paperwork. Sometimes doctors will make a determination without all the facts about the employees' work responsibilities. We will work with you, the carrier, and the medical provider to ensure that the employee returns to work as quickly as possible.

**The employee went to the doctor. They claim to be fine but didn't bring back any paperwork. What should I do?** If the employee receives treatment from a medical facility and he/she returns to work "full-duty" with no restrictions, a release from the treating physician must be obtained before the employee may begin work. Call the clinic and have them email/fax the paperwork or send the employee back to obtain the release. You cannot allow them to work without a written release from the treating facility.

**Can the employee go anywhere they want for treatment, like to their personal doctor?** Absolutely NOT. The employee must go to an approved facility and all visits after the initial care MUST be authorized by the carrier.

**How many witnesses need to fill out the Witness Statement Form?** If possible, have ALL of the witnesses fill out the form. Often times you will get different accounts that can help in the investigation. Also, should the employee get a lawyer, witness statements help in the defense of the lawsuit.

**How do I report a claim that happens after normal business hours?** You can call the CHR corporate headquarters like you would call during regular business hours and leave a message. You can send an email or fax. If you need to speak with someone immediately, you may contact Phil Herron on his cell at 678-988-8544. If he does not answer please leave a message and he will get back to you ASAP. The office phone number is 239-415-1110 and the fax number is 239-592-9800. At any time, to email information about a claim please send it to [claim@continuumhr.com](mailto:claim@continuumhr.com).

**If an employee is involved in auto accident while working, do I need to report it to workers' compensation? If so why?** If an employee is injured while performing a job function for the company (even if that function involves driving or riding in a vehicle), it is a workers' compensation claim. The work comp carrier can then try to recoup some of the costs of the claim from the responsible parties auto carrier.

**What information is helpful during an investigation of an injury?** Pictures, documentation, and witness statements. Take pictures of the equipment and area the employee was working in when the injury happened? Use an item to show scale if possible. Have a person stand in the picture to point out the specific area, part, or location where or how the injury occurred. Document everything; claims forms, name and type of equipment involved (model and SN if applicable), and witness statements.

**When an employee has filed a claim and has returned to work on light duty, can they come and go as they please?** No. The light duty restrictions will detail if a reduction of hours is necessary for the proper healing of the injury. Other than for medical treatments and/or evaluations, the employee should be expected to maintain a normal work schedule.

**Can I fire an employee that has filed a claim?** NO! There are very few circumstances that allow for terminating an injured employee without severe penalties to you and your business. In addition, you/we lose complete control of making sure the injured employee follows the medical orders, goes to appointments and treatments, and inevitably the cost of the claim soars. **CALL US** and we will discuss the situation and assist you with getting the immediate problem corrected.

**Can I fire an employee after their claim has been closed?** It is against the law to terminate an employee for being injured at work whether the claim is open or closed. However, you can terminate the employee for cause for misconduct or performance reasons with proper written documentation showing a disciplinary process has been followed. **CALL US FIRST to review the circumstances and to receive guidance.**

**If an employee tells me they had an accident on the job, but they don't want to go to the doctor, do we report this?** YES! The employee must fill out the refusal form (AR-6) and it must be sent to us immediately. There are many times where an employee initially refuses treatment and then later decides to go. Late reporting causes a number of problems including having to remember forgotten details and possible fines from the state.

**Why must the employee take a drug test immediately after being injured?** The carrier requires that a drug test be performed. In addition, some states require the test to be performed within hours of the incident. To be accepted as part of the claims process, the test has to be timely in relation to the accident. Also, should an employee test positive for drugs or alcohol, by law the compensation benefits can be reduced or the claim can be denied outright. This has the potential of saving YOU money.

**Can we reduce the wages of an injured employee working light duty work?** The employee should be paid as close to their normal wages as possible based on the restrictions and work that is available. An employee returning to work but unable to perform their normal duties can be assigned other duties that meet the light duty restrictions. The employee only has to be paid what the interim job is worth, but it SHOULD be at least 80% of their current pay. If the employee meets the requirements, a percentage of the difference between the two wages will be made up by the workers' compensation carrier. **If you choose to pay a lower than current wage, please call CHR and let us know so that we file the correct paperwork to ensure that the employee is paid what they are owed.**

**Must we work an injured employee their normal work hours/shift?** It is always better for the overall cost of the claim to have the employee work a normal schedule if the restrictions allow it. If you do not have enough light duty work to support a regular shift, you do not have to create work to keep the employee busy. If you are having difficulty providing hours to an injured employee, please contact CHR and we discuss the situation with you.

<b>Workers' Compensation Commission (WCC)</b> <b>Employees' and Physicians' Report of Injury</b> Prior To Completing This Form You Must Read The Instructions On The Back Of This Form.		<b>WC-1</b>		<b>Claim Number:</b> _____ <b>Team Assigned:</b> _____ <b>ICD9:</b> _____	
<b>Section I All Information Must Be Completed by Injured Employee</b>					
The receipt of a claim number does not entitle an employee to benefits under WV Workers' Compensation Law. In signing this form, I certify the statements and answers set forth are true and correct. I am aware the law provides for severe penalties if I knowingly provide a false statement or withhold a material fact or statement respecting any information requested by the Commission. <b>Initials of Injured Employee:</b> _____					
1. Name: Last _____		First _____		MI _____	
2. Social Security Number: _____ - _____ - _____			Marital Status: _____		
3. Injury/Last Exposure Date: ____/____/____		Time: _____		<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
4. Address: _____					
City: _____		County: _____		State: _____ Zip: _____	
5. Telephone: ( _____ ) _____ - _____		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth: ____/____/____	
6. Time You Began Work on Date of Injury: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.					
7. Date Stopped Work for Injury: ____/____/____		Time: _____		<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
8. Body Part(s) Injured: _____					
9. How Did Injury Occur? (Specify the cause, what you were doing, and equipment/objects involved): _____					
10. Job Title/Description: _____					
11. Did Injury Occur on Employer's Property? <input type="checkbox"/> Yes <input type="checkbox"/> No Address where injury occurred: _____					
12. Employer Name and Address: _____					
City: _____		County: _____		State: _____ Zip: _____	
Telephone Number : ( _____ ) _____ - _____		Supervisor's Name: _____			
13. If Public Employee, Check One (If County Board of Education employee, complete the County Board Option Form):					
<input type="checkbox"/> Use Sick Leave		<input type="checkbox"/> Draw Temporary Total Disability Benefits			
I certify the statements and answers set forth in this section are true and correct to the best of my knowledge and belief. I am aware the law, specifically § 61-3-24f, provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I authorize any physician to release to or orally discuss with, either my employer or an authorized agent of the Workers' Compensation Commission, any medical records pertaining to the occupational injury or illness for which I am claiming benefits and any prior injury to or disease to the portion of my body for which I am alleging a medical impairment. I acknowledge the provisions of WV Code § 23-4-7 providing authorization for release of medical information by a physician to my employer or employer representative.					
<b>Employee's Signature:</b> _____ <b>Date:</b> ____/____/____					
<b>Section II All Information Must Be Completed By Initial Provider</b>					
I have been informed of my responsibilities under WV Workers' Compensation Law and agree to abide by such in the administration of services provided by the Commission. I understand the submission of false statements or billing will result in the termination of my contract as well as prosecution under state and federal law. <b>Initials of Provider/Physician:</b> _____					
1. FEIN or SSN: _____		Name of Physician/Hospital: _____			
2. Address: _____			Telephone: ( _____ ) _____ - _____		
City: _____		County: _____		State: _____ Zip: _____	
3. Date you were first consulted for this condition? ____/____/____			Date Employee was/will be able to return to work: ____/____/____		
4. Condition is a result of: <input type="checkbox"/> Occupational Injury? <input type="checkbox"/> Occupational Disease? <input type="checkbox"/> Non-Occupational Condition?					
5. Disability Period: <input type="checkbox"/> Less than 4 days <input type="checkbox"/> 1 Week <input type="checkbox"/> 2 Weeks <input type="checkbox"/> 3 Weeks <input type="checkbox"/> More than 4 Weeks					
6. Can employee return to modified work? <input type="checkbox"/> Yes <input type="checkbox"/> No					
7. Nature, Body Part and Type of Injury:			Diagnosis Code(s) (ICD9-CM) in Order of Severity: _____		
7a. Nature: _____		_____			
7b. Body Part: _____		7c. Type of Injury: _____			
8. Did this injury aggravate a prior injury/disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Explain: _____					
9. Name and address of physician referred to: _____					
10. If claimant was hospitalized, where? _____					
I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law, specifically § 61-3-24g, provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge my contractual obligations to the Commission and agree to release any office notes/test results immediately to the Commission.					
<b>Physician's Signature:</b> _____ <b>Date:</b> ____/____/____					

**General Instructions for Completing the  
WC-1, “Employees’ and Physicians’ Report of Injury”**

**- Please Read Carefully -**

**General Overview:** The claim initiation process now involves the filing of two individual forms:

**WC-1, Employees’ and Physicians’ Report of Injury:** To be completed by the injured employee and the medical provider.

**WC-3, Employers’ Report of Injury:** To be completed by the employer

A claim cannot be established until the Workers’ Compensation Commission has received at least one of the forms listed above. This form should not be used to file occupational pneumoconiosis or hearing loss claims.

Please note that W.V. Code 23-4-1 provides that employees of the state and its political subdivisions are ineligible to receive workers’ compensation benefits while drawing sick leave benefits at the same time for the same reason. **You must make your choice known in Question 13 of this form.**

**To the Injured Worker:** Section I of this form must be completed by you. **When you have completed this form, make a copy for your records, and make a copy to give to your employer.** The initial medical provider is responsible for completing Section II of this form, and your employer is responsible for completing the WC-3, Employers’ Report of Injury. Both the provider and employer will be required to send the signed completed forms to the Commission. If you do not receive a decision on your claim within **14 days** after sending the form, contact Workers’ Compensation Commission. The responsibility of filing a claim rests with you. To be eligible for benefits, **your claim must be filed with the Commission within six months** from and after the injury or death. If you have any questions, you may contact the Commission at 1-800-231-4850 or visit our Web site at [www.wvcc.org](http://www.wvcc.org).

**To the Initial Medical Provider:** Section II of this form must be completed by you. The timely provision of information regarding the injured worker’s condition is vital in deciding eligibility for benefits. Each answer should be as specific as possible. You should immediately send a copy of all records, office notes, and test results regarding the injured worker’s exam to Workers’ Compensation Commission. **After completing this form, please make two copies – one for your records and one for the injured worker to take to the employer. Your office is responsible for sending the signed original form to the Workers’ Compensation Commission.** If you have any questions, you may contact Workers’ Compensation Commission at 1-800-628-4265 or visit our Web site at [www.wvcc.org](http://www.wvcc.org).

**Section I**

Question Number	Explanation
3.	This date is defined as either the date you were injured or the date you were last exposed if you are filing an occupational disease claim.
8.	List part(s) of body injured.
9.	Your description of how the injury occurred is reviewed to determine eligibility for benefits.
10.	Describe the job you are currently working. If you are a state, municipal, or county employee, you need to include that in the information. (i.e. construction workers for the state.)
13.	According to the Workers' Compensation Temporary Total Disability Benefits/Sick Leave Policy, if you are absent from work due to a work-related injury, you must choose to receive <u>either</u> Temporary Total Disability benefits (TTD benefits) from Workers' Compensation or paid sick leave. If you elect to receive TTD benefits, you may use sick leave <u>until</u> you receive your initial TTD benefit check; however, this leave will be restored when you reimburse your employer the net value of the paid sick leave used, according to the provisions of this policy.

**Section II**

Question Number	Explanation
1.	Federal Identification Number or Social Security Number and name, facility or group name you report to Workers’ Compensation Commission for billing purposes.
4	In your opinion, was the patient injured at work, exposed to a disease at work, or is the condition not work related?
7a.	Define injury. (i.e., sprain/strain, fracture, laceration)
7b.	Part(s) of body injured.
7c.	How injury occurred. (i.e., lifting, fall, motor vehicle accident)
8.	Describe in detail what effect, if any, the patient’s previous health may have on this injury.

Please mail the completed form to: **Workers’ Compensation Commission  
P. O. Box 431  
Charleston, WV 25322-0431**

*When completing this form, enclose attachments if additional space is needed.*







## SUPERVISOR'S ACCIDENT INVESTIGATION REPORT AR - 2

Client:	Employee:
Date of Injury:	Time of Accident: <span style="float: right;">AM/PM</span>
<b>Chain of Custody Number/ Drug Test Form #:</b>	Department:
Date the employee reported the accident to you:	

### Please Complete All Questions

Has the injured employee requested medical treatment?  Yes  No

(Have employee complete refusal of treatment "Form AR-6" - if applicable)

Job being performed: \_\_\_\_\_ Was this his/her regular job?  Yes  No

Place of Job (parking lot, garage, residential home): \_\_\_\_\_

Job Site Address (be specific) \_\_\_\_\_

How many hours was the employee on the job before the accident occurred? \_\_\_\_\_ Start Time: \_\_\_\_\_

Last full day worked before injury: \_\_\_\_\_ County of Injury: \_\_\_\_\_

Describe the Accident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What did employee do or fail to do that contributed to the accident? \_\_\_\_\_

\_\_\_\_\_

What body part was injured? \_\_\_\_\_ Any Witnesses:  Yes  No

Were you present at the accident location during the incident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you witness the incident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there issues or circumstances that make you question the employees' account of the incident or nature/severity of the injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Was a post-accident drug screen performed?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is light duty available for this injured employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you believe the employee will lose time from work beyond medical treatments?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was the employee cited for the accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was employee paid for the rest of the day? If No, when was last hour paid thru? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did the employee willfully refuse to use a safety appliance or have prior knowledge and willfully refused to observe a safety standard or rule?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Where did the employee go for treatment (Name of clinic/hospital)?** \_\_\_\_\_

Clinic/ Hospital Address and phone #: \_\_\_\_\_

How were they transported to treatment (car, ambulance)? \_\_\_\_\_ Work Status: \_\_\_\_\_

Was the accident a result of  Unsafe Act or  Unsafe Condition? First day of treatment? \_\_\_\_\_

Supervisor Print Name \_\_\_\_\_ Signature of Supervisor \_\_\_\_\_

**Direct Phone/Cell Line:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Fax or email to Claims Center at 239-415-1114 or [claim@continuumhr.com](mailto:claim@continuumhr.com)**





**AR - 4**

## Consent For Release Of Medical Information

I hereby authorize representatives of Continuum HR and / or Continuum HRs' Workers' Compensation Carrier to be permitted to obtain and review copies of all medical records related to my workers' compensation injury. This pertinent information will be discussed with other professionals involved in my medical treatment and any institution that, through the "Workers' Compensation Program" or otherwise is paying all or part of the cost associated with my medical care.

Employee Name	Social Security Number
Injury Date	Telephone Number
Name of Employer	
Signature of Employee	Date
Witness	Date

**A PHOTOCOPY OR FACSIMILE COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL**

Fax or email to Claims Center at 239-415-1114 or [claim@continuumhr.com](mailto:claim@continuumhr.com)



**MEDICAL AUTHORIZATION FOR INITIAL TREATMENT** **AR - 5**

To: Medical Treatment Facility,

Please **verify** the active status of the injured employee being treated by calling us at 239-415-1110. You are authorized to give a **ONE TIME INITIAL** treatment as necessary to our employee. **Please ensure all injured employees are drug tested or** told to go to the designated facility.\*

**\*If drug test collection is not performed at this location, please advise the Employee to go to the drug test location listed on the chain of custody form.**

Employee Name	Social Security Number

Authorized by:  
Continuum HR  
11691 Gateway Blvd Ste 104  
Ft. Myers, FL 33913  
(239) 415-1110

Send billings to:  
Continuum HR  
11691 Gateway Blvd Ste 104  
Ft. Myers, FL 33913  
(239) 415-1110

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Please fax or email all treatment records including restrictions to Continuum HR following treatment.

*We require all physicians who provide treatment for a reported work related injury submit all relevant documents to the insurer and the employer immediately but no later than three (3) business days after the visit.*

**Please fax or email all medical paperwork to 239-415-1114, Attention Claims Center or [claim@continuumhr.com](mailto:claim@continuumhr.com)**

If possible, inform us of any follow up treatment and also of any **missed** appointment by calling our offices at 239-415-1110.

**Please Ensure All Injured Employees are Drug Tested.**

Note to **Client/ Employer**: Employee must carry a chain of custody form **AND** this authorization form to the assigned Medical Treatment Facility and/or pharmacy.



## REFUSAL OF TREATMENT FORM **AR – 6**

<b>Client:</b>	<b>Incident Date:</b>
<b>Employee:</b>	<b>Social Security:</b>
<b>Employee Phone:</b>	<b>Incident Location:</b>

I was involved in an incident on the above-mentioned date. I sustained no injuries. I was offered medical attention, but saw no need for medical treatment, because I sustained no injuries in the incident.

If my condition changes in the future, I agree to notify my supervisor and call the CHR Claims Center at 239-415-1110. I realize that medical treatment will be provided and I will receive authorization so that I might obtain medical attention, which, at this time, I have refused.

Please describe the incident in detail:
Please list specific body parts affected (i.e. Right thumb, Upper back, Left ankle, etc.):
The following people may have been a witness to the incident:

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

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Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

Fax or email to Claims Center at 239-415-1114 or [claim@continuumhr.com](mailto:claim@continuumhr.com)



# RETURN TO WORK

## Purpose

The purpose of a Return To Work program is to enable the employee to work and be productive during the period of the employees' recovery from an injury. This not only allows you to retain experienced staff, but also reduces the cost of the claim and increases employee morale.

CHR has established guidelines to return an injured employee to work following their injury as set forth in our contract. The employee will be placed on "light duty" (modified duty, transitional duty, limited service) as soon as he or she is able to do so prescribed by the treating medical provider. You are required to make light duty work available, as long as the restrictions are within reason, as soon as the employee is released to work by the treating physician. If you feel the restrictions are burdensome or if you have no work available, call us IMMEDIATELY and we will work with you, the doctor, the carrier, and the employee, so that YOU can keep your claims costs low and productivity high.



## **Lost Time / Return To Work FAQ**

**How often should I talk to an employee that has been placed out of work by the doctor?** You should require the employee to call or visit your establishment a minimum of once per week. If the employee has been to the doctor, require the employee to drop off or send in any medical paperwork they have received immediately. Ask the employee how they are doing, when their next treatment is, and when they expect to return to work. Report any new information to CHR.

**What do I need to do when an employee returns to work after missing time from an injury?** Verify that the employee has obtained a release from the doctor by either A) reviewing the medical release supplied by the employee from the doctor, or B) calling CHR and have us verify the release. Sometimes an overeager employee will say they have been released and it not be true.

**The employee has doctor restrictions and has returned to work. What do I need to do?** Sometimes an employee may be released from the doctor to return to work with physical restrictions. The supervisor and the employee must review these restrictions carefully and discuss what work the employee can do within the limitations set by the medical provider. Do not allow the employee to work beyond those restrictions or it may impede the healing process or possibly make the injury worse.

**What should I do if an employee has been released to work but doesn't show up for their shift?** Try to contact the employee and ask why they are not present. Report the "No-Show" and any findings to CHR. Even if you choose not to discipline the employee, document the absence and have the employee sign it upon their return. It is imperative that you notify and submit the documentation to CHR so that we can properly manage the claim and keep the costs to a minimum.

**Will an employee be paid if they miss time due to an injury?** Possibly. The first seven (7) days of lost time work is not payable by the workers' compensation system. In addition, if the doctor does not place the employee "off work" and/or if the employee *CHOOSES* to stay home, they will not be compensated. If you wish to pay the employee (by using vacation time, etc.), contact the Claims center at (239) 415-1110 for a discussion of the proper method. **Do not just put them on the payroll.** If, however, the treating physician places the employee off work for more than 7 days, they will be paid a portion of their average wages.

**How are lost time wages calculated?** – Depending on individual state statutes, loss wages are calculated based on average wages earned over a set period of time. Usually, an injured employee will receive sixty six and two thirds (66 and 2/3rds) of the calculated average wage.

Example: Florida uses the 13 weeks leading up to the injury date to calculate the average pay.

Example: Georgia uses the previous years' earnings to calculate the average pay.

If there is not enough historical data to support the primary method for calculation, a "similar" employee (in position, duties, and pay) is selected and their time and earnings are used to establish an average wage for the injured employee.

**When can my employee expect to receive their benefit check(s) from the carrier?** – After the injured employee is eligible to receive benefits, the carrier then begins to process the benefit payment. Payments will be sent directly to the employee on a bi-weekly cycle.

**What if my company does not have light duty available?** Only in extreme cases are there no possibilities for making light duty available. Call CHR immediately and we will discuss with you the light duty restrictions and ways to get the employee back to work. Return To Work programs have been proven to reduce the costs of claims by 10% to 30%. We have access to several Return To Work options that you may not be aware of.

**How do I let an employee know I have light duty available? What should I do to protect our company when we offer an injured employee light duty work?** If the employee is present, sit down with them and the supervisor and discuss the light duty. Have the details put on paper and have the employee sign. Some states require that a formal light duty job offer be in writing and have a detailed job description that meets the restrictions. You must specify a date and time the employee is to report and exactly who the employee is to report to. The document must be sent to the employee certified mail, Fed Ex (signature required), or hand delivered to the employee with a receipt signature. The date the employee must report to work must allow for the time it takes to have the letter delivered (usually 5 days). The employee must be made to sign and date the document and return it for your files (copy to CHR). Even if this is not required in your state, it remains an excellent way to protect your business. **CHR has developed a document for this purpose and we will be happy to assist you on its completion.**