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 Choice HR immediately -** fill out and email/fax **Form 4 (First Notice of Injury)**
   - The injury may be reportable to OSHA or your state. Ask Choice HR 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 Choice HR immediately -** fill out and email/fax **Form 4 (First Notice of Injury)**
   - The injury may be reportable to OSHA or your state. Ask Choice HR for guidance.

All forms are included in this packet and also available online at www.choicehr.com within the Form Center Tab. You can also call CHOICE HR 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 Choice HR 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. If the treating physician prescribes medication, the injured employee will need this to provide this form to the network pharmacy. 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-Lab-Corp (1-800-522-2677) to locate a facility.

FORM 4: First Notice of Injury Report - Fill out the **First Notice of Injury Report** and email it to: **wcclaims@choicehr.com** or fax (813) 643-4441 it to CHOICE HR. 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 Choice HR at **813-643-4000** during normal business hours.

Insured: CHOICE Employer Solutions, Inc.

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

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 CHOICE HR within a 24-hour period.

Form 2

Post-Accident Drug Testing Form

LabCorp

Laboratory Corporation of America

LABCORP WEB COC FORENSIC (non-DOT) COLLECTION AUTHORIZATION FOR

DONOR NAME: _____

COLLECTOR:

Specific account information for collection services for this donor:

*** ASAP/Choice Employer Solutions

*** LabCorp Account #: 514581

Location Code (If Required): 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

***REQUIRED FIELDS

EMPLOYER/DONOR:

To locate a LabCorp Collection site location with WEB Chain of Custody Capability, go to www.applicant360.com, click on the login tab located at the top of the page, then click Web Chain of Custody collection site locator or call **888-522-2677.**

If you have any questions, please contact: Client Services at: 800-329-6334; Option 2.

FOR LABCORP PERSONNEL ONLY: OTS TECH SUPPORT HOTLINE

800 833-3984 Extension 5380

Form 3

Pharmacy Prescription Card

OPTUM℠

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

OPTUM

AmTrust North America

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		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®

Form 4 First Notice of Injury Form

Please fax or email this form to Choice Employer Solutions at **813-643-4441** or wcclaims@choicehr.com **immediately** or **within 24 hours** after a workplace injury.

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 Name (printed)		Supervisor 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:
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 anyother 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 ☐No	If yes, what date? If no, last date employee 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 Choice Employer Solutions (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