US ADMINISTRATOR
CLAIMS

CLAIM REPORTING

866-253-6019

or

AccreditedWC@USAdminclaims.com

When an injury occurs, call 866-253-6019 or complete the First Report of Injury form (available at www.usadminclaims.com/claims) and email the form to AccreditedWC@USAdminclaims.com.

Please have the following information ready:

1. **Your Company's name and location**
2. **Date of injury**
3. **Injured Employee's:**
   - **Full Name**
   - **Social Security Number**
   - **Home Address**
   - **Phone Number**
   - **Job Title**
   - **Rate of Pay**
   - **Hire Date**
4. **Description of Incident**
   - **What caused the accident?**
   - **What was the nature of the employee's injury?**
   - **What body parts were affected?**
   - **Names of witnesses?**
5. **Initial treatment**

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MEDICAL TREATMENT INJURY PACKET

INSURED INFORMATION

Insured Name: _____ State: _____

Insured Contact: _____ Phone: _____

INJURY DETAILS

Employee Name: _____ SSN: _____ DOB: _____

Type of Injury: _____ Date Insured Informed: _____

Full Address of Accident Site: _____

City: _____ State: _____ ZIP: _____

CHECKLIST TO SEND TO US ADMINISTRATOR

- ☐ INJURY PACKET COMPLETED IN FULL
- ☐ STATE SPECIFIC FORMS/PANELS INCLUDED *(IF APPLICABLE)*
- ☐ PHOTO OF EMPLOYEE HOLDING PANEL *(IF APPLICABLE)*
- ☐ PERSONNEL FILE, POST-HIRE MEDICAL QUESTIONNAIRE AND PAYROLL INFORMATION
- ☐ EMAIL ALL ITEMS TO **WC@USADMINCLAIMS.COM**
- ☐ SEND PICTURES AND/OR VIDEOS OF THE ACCIDENT
- ☐ IF EMPLOYEE IS LOSING TIME DUE TO THIS INJURY, PLEASE INCLUDE 52 WEEKS OF WEEKLY WAGES.

NOTE: THE EMPLOYEE WILL NEED TO COMPLETE THE MEDICAL AUTHORIZATION FORM INCLUDED IN THIS PACKET AND TAKE IT WITH THEM TO THE TREATING CLINIC.

EMPLOYEE SHOULD BE PAID FOR A FULL SHIFT FOR THE DAY OF INJURY.

PROTECTIVE EQUIPMENT

Were they wearing the required safety equipment? ☐ YES ☐ NO

If YES, please list:

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MEDICAL TREATMENT INJURY PACKET
PAGE 2 - FILLED OUT BY EMPLOYER

ANY OTHER PERTINENT INFORMATION

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MEDICAL TREATMENT INJURY PACKET
PAGE 3 -FILLED OUT BY WITNESSES

WITNESS STATEMENTS

Please have each witness fill out this page (make copies if necessary, for additional witnesses)

Witness Name: _____ Phone: _____

Full Address: _____

City: _____ State: _____ ZIP: _____

Company Name: _____ Position with Company: _____

Name of injured worker you observed: _____

Did you witness what the injured employee was doing when the injury occurred? ☐ YES ☐ NO

If YES, please describe in detail the accident:

SIGNATURE

I, _____, certify the above statement is true and correct.

SIGNATURE: _____ DATE: _____

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MEDICAL TREATMENT INJURY PACKET
PAGE 4: FILLED OUT BY INJURED EMPLOYEE

PERSONAL DETAILS

Name: _____ Social Security #: _____

Email Address: _____ Phone: _____ DOB: _____

Full Mailing Address: _____

ACCIDENT DETAILS

Date & time of accident: _____ Date injury reported to supervisor/employer: _____

Location name and full address where accident occurred:

Were there any witnesses to the accident? ☐ YES ☐ NO

If yes, please provide their name(s):

SAFETY

When you were hired, did you watch the employer's safety video? ☐ YES ☐ NO

Did the employer explain to you the requirements of the job? ☐ YES ☐ NO

Was safety equipment provided? ☐ YES ☐ NO

Were you performing your regular assigned work when the accident happened? ☐ YES ☐ NO

In your opinion, was there something, in general, that could have been done differently to prevent the accident? ☐ YES ☐ NO

If yes, please describe:

In your opinion, what caused the injury?

☐ Poor Conditions ☐ Machine/Equipment Failure ☐ Employee Fault ☐ Poor Training ☐ Employer Fault

☐ Other or N/A: _____

Warning: providing false or misleading information on any company document may result in disciplinary action including but not limited to termination of employment. By initialing here, you are acknowledging that the information listed on this form is accurate. False or misleading information may have an effect on your employment status.

Initials: _____ Date: _____

SIGNATURES

Employee Name: _____

Employee Signature: _____ Date: _____

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MEDICAL TREATMENT INJURY PACKET
PAGE 5 - FILLED OUT BY INJURED EMPLOYEE

INJURED EMPLOYEE'S STATEMENT

Describe in your own words how the injury/accident occurred:

Were you instructed to do the specific task you were doing when the accident occurred? ☐ YES ☐ NO

If YES, by whom? _____

Were you trained to do the task before the actual work began? ☐ YES ☐ NO

If YES, by whom? _____

Please describe any safety hazards you observed:

I certify that the above statements are true and correct. Employee Name: _____

Signature: _____ Date: _____

DESCRIPTION OF EMPLOYEE'S JOB DUTIES

Job Title: _____ Hours per day: _____ Per week: _____

Rate of pay: $_____ per _____ WC Code: _____

NOTE: PLEASE INCLUDE 52 WEEKS OF WAGES

Describe all job duties in detail and include machinery and equipment used:

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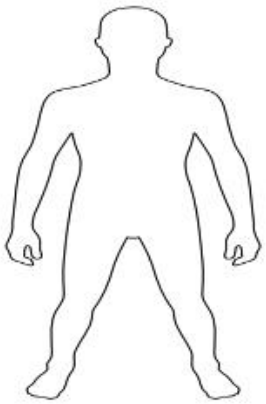
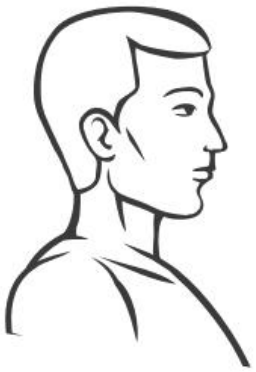
PAGE 6 - FILLED OUT BY INJURED EMPLOYEE

INJURY DIAGRAMS *(FILLED OUT BY INJURED EMPLOYEE)*

INDICATE TYPE OF DISCOMFORT WITH THESE SYMBOLS ON THE BELOW DIAGRAMS:

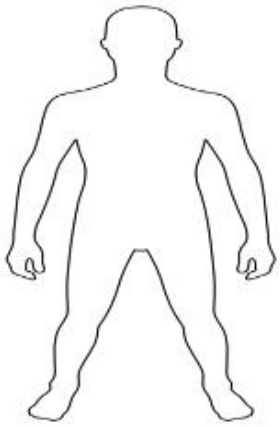
BURNING: + NUMBNESS: = STABBING: // CRAMPING: X PINS & NEEDLES: 0 ACHING: >>

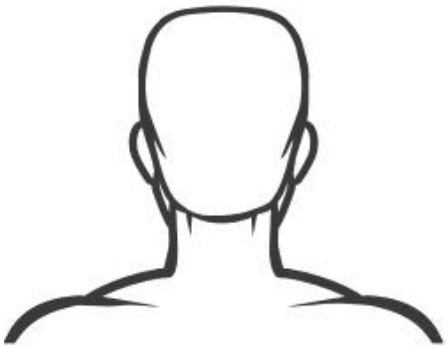


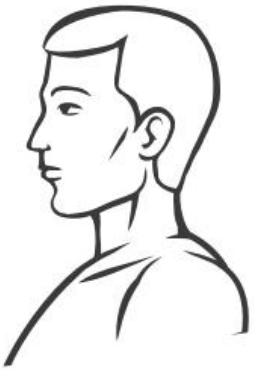


PAIN LEVEL (1-10): _____ PAIN LEVEL (1-10): _____ PAIN LEVEL (1-10): _____

BODY PART: _____







PAIN LEVEL (1-10): _____ PAIN LEVEL (1-10): _____ PAIN LEVEL (1-10): _____

(BACK & NECK)

I, _____*(print name)*, declare under penalty of perjury that I have personally completed the above body and head diagrams. I further declare that the injuries indicated are the only areas of injury related to the alleged work injury documented here and/or to my employment.

EMPLOYEE NAME: _____

EMPLOYEE SIGNATURE: _____

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MEDICAL TREATMENT INJURY PACKET
PAGE 7: FILLED OUT BY INJURED EMPLOYEE
COPY TAKEN TO MEDICAL PROVIDERS

POST INCIDENT EMPLOYEE ACKNOWLEDGEMENT AND AUTHORIZATION FOR RELEASE OF EMPLOYMENT AND MEDICAL RECORDS

*****A COPY OF THIS FORM MUST BE GIVEN TO THE MEDICAL PROVIDER (MPN IN CA)*****

THIS FORM DOES NOT GUARANTEE BENEFITS OR PAYMENT.

EMPLOYEE NAME: _____

SOCIAL SECURITY NUMBER: _____ CURRENT JOB TITLE: _____

DATE OF HIRE: _____ DATE OF ACCIDENT: _____

I, _____ understand there will be drug/alcohol screened by the treating clinic.

I also understand that **I must return all work status and/or doctors reports to my Employer immediately** after each visit from the medical facility. Failure to report for light duty may affect workers compensation benefits.

TO WHOM IT MAY CONCERN:

PERMISSION IS HEREBY GIVEN TO FURNISH AND RELEASE TO **U.S. ADMINISTRATOR CLAIMS**:

1. ALL MEDICAL RECORDS PERTAINING TO THE EXAMINATIONS, TREATMENTS OR CONSULTATIONS INCLUDING BUT NOT LIMITED TO: BILLING RECORDS, X-RAYS, MRIs AND DIAGNOSTIC TESTING INCLUDING REPORTS, HISTORY RECORDS, DIAGNOSIS AND PROGNOSIS RECORDS; NURSE AND DOCTOR NOTES AND ALL REPORTS;AND ANY PSYCHIATRIC OR MENTAL HEALTH RECORDS; AND ALL REPORTS RELATED TO DIAGNOSIS, CARE AND TREATMENT FOR DRUG AND ALCOHOL ABUSE.
2. ALL EMPLOYMENT RECORDS PERTAINING TO EMPLOYMENT WITH YOUR COMPANY, INCLUDING BUT NOT LIMITED TO: PERSONNEL RECORDS, PAYROLL RECORDS, MEDICAL RECORDS AND TIME RECORDS.
3. I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME BY WRITING TO THE HEALTHCARE PROVIDER LISTED ABOVE. UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN BASED ON THIS AUTHORIZATION.

I UNDERSTAND THAT THE INFORMATION OBTAINED WILL BE USED BY THE CARRIER, EMPLOYER, AND THIRD-PARTY ADMINISTRATOR, OR ANY REPRESENTATIVES THEREOF, FOR THE EVALUATION AND PROCESSING OF ANY CLAIM(S) FOR WORKERS COMPENSATION BENEFITS AS A RESULT OF ANY CLAIMED WORK-RELATED INJURIES. I DO NOT GIVE PERMISSION FOR ANY OTHER USE OR RE-DISCLOSURE OF THIS INFORMATION.

THIS AUTHORIZATION IS VALID UNTIL MY CLAIM HAS BEEN ACCEPTED OR DENIED, BUT IN NO EVENT BEYOND ONE YEAR FROM THE DATE OF MY CLAIMED INJURY. A PHOTOCOPY OF THIS AUTHORIZATION IS AS EFFECTIVE AS THE ORIGINAL.

I UNDERSTAND THAT I AM ENTITLED TO A COPY OF THIS AUTHORIZATION.

NOTE TO MEDICAL PROVIDER:

- WHEN PERMITTED AND ORDERED, A RAPID (IF AVAILABLE) 9 OR 10 PANEL DRUG SCREEN IS REQUIRED WITH MRO CONFIRMATION OF NON-NEGATIVE RESULTS
- US ADMINISTRATOR ADHERES TO A STRICT RETURN TO WORK PROGRAM AND WILL MAKE EVERY EFFORT TO ACCOMMODATE THE RESTRICTIONS GIVEN (IF ANY) TO RETURN THIS EMPLOYEE TO LIGHT/MODIFIED DUTY
- SUBMIT ALL DRUG/ALCOHOL SCREEN RESULTS AND WORK STATUS UPDATES DIRECTLY TO US ADMINISTRATOR CLAIMS EITHER BY EMAIL: WC@USADMINCLAIMS.COM OR VIA FAX: 866-647-0620. CALL 866-986-3316 WITH ANY QUESTIONS.
- ALL TREATMENT BILLING FOR WORKERS' COMPENSATION CLAIMS WILL BE COORDINATED VIA THE ADJUSTER OF U.S. ADMINISTRATOR CLAIMS AT: P.O. BOX 2005, OAK RIDGE, TN 37831.

Employee Signature: _____ Date: _____

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MEDICAL TREATMENT INJURY PACKET
PAGE 8: FILLED OUT BY INJURED EMPLOYEE
IF TREATMENT IS REFUSED

REFUSAL OF MEDICAL TREATMENT

I, _____(EMPLOYEE NAME), REPORT BEING INVOLVED IN A WORK-RELATED INCIDENT ON _____(DATE), WHILE EMPLOYED BY_____ AND REFUSE MEDICAL TREATMENT AT THIS TIME.

☐ I HAVE RECEIVED FIRST AID ONLY *(AT MY WORKPLACE, NOT AT A CLINIC OR MEDICAL FACILITY)*

☐ I WAS SHOWN AND/OR GIVEN THE PANEL OF PHYSICIANS/MPN *(IN APPLICABLE STATES ONLY)*

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT SHOULD I NEED MEDICAL CARE IN THE FUTURE FOR THIS INCIDENT, I WILL NOTIFY AN EMPLOYER REPRESENTATIVE IMMEDIATELY TO ENSURE THAT I RECEIVED TIMELY AND APPROPRIATE CARE. I UNDERSTAND THAT IF I CHOOSE TO RECEIVE MEDICAL CARE I WILL BE REQUIRED TO SUBMIT TO A POST-INJURY DRUG SCREEN AT THE TIME OF TREATMENT. FAILURE TO NOTIFY MY EMPLOYER OF ANY CHANGE OF CONDITION MAY RESULT IN DISCIPLINARY ACTION.

EMPLOYEE SIGNATURE: _____ DATE: _____

INSURED REPRESENTATIVE SIGNATURE: _____ DATE: _____

24 HOUR FOLLOW UP

I, _____(CLIENT REPRESENTATIVE) CALLED THE INJURED EMPLOYEE ON _____ (DATE) TO HECK ON THEIR CURRENT MEDICAL AND WORK STATUS. I DOCUMENTED THIS INFORMATION IN THE EMPLOYEE'S HR FILE.

INSURED REPRESENTATIVE SIGNATURE: _____ DATE: _____

U.S. ADMINISTRATOR CLAIMS

MEDICAL TREATMENT INJURY PACKET
PAGE 9: FILLED OUT BY EMPLOYER AND EMPLOYEE

MODIFIED DUTY POLICY

THIS FORM IS ONLY REQUIRED IN INSTANCES WHERE A TREATING PHYSICIAN RELEASES AN INJURED WORKER TO WORK LIGHT OR MODIFIED DUTY.

EMPLOYEE NAME: _____ EMPLOYER: _____

LOCATION: _____ MODIFIED POSITION OFFERED: _____

DATE OFFERED: _____ DATE POSITION BEGINS: _____

HOURLY PAY RATE: _____ TOTAL WEEKLY HOURS BEING OFFERED: _____

SHIFT START TIME: _____ SHIFT END TIME: _____

DESCRIPTION OF DUTIES:

It is preferred that all modified duty employees schedule their therapy and doctors' visits around their scheduled work shift when possible.

All light duty employees are required to abide by the following guidelines while performing work at client offices and sites:

- Remain in designated work area and perform all functions assigned by client and within doctor's restrictions.
- Do not interfere, interrupt or disturb the operations of the client site and their staff.
- Use of cell phones or computers while assigned to the client site is not permitted unless required by the assignment.
- Light Duty employees are to have NO access to confidential information and are not to perform tasks which are normally performed by client employees.

It is the responsibility of the modified duty employee to schedule or provide their own transportation to home and the assigned work location. Mileage reimbursement where applicable by law will be provided for transportation to doctor and therapy visits. It is the responsibility of the modified duty employee to keep track of their time sheet and have time verified, signed and turned into client. All modified duty employees are expected to adhere to their assigned shifts and unapproved/unexcused tardiness, or absences will be managed via the company standard disciplinary policies. Approved excused include:

- Doctors' appointments (A note must be provided).
- Sickness (if over 2 days, doctor's note must be provided to return to modified duty).
- Pre-approved absences or tardies (must be pre-approved)

The company and client will abide by the terms of restrictions set forth by injured employee's treating doctors and expect that they will do the same at work and elsewhere.

I, _____, acknowledge I have received and understand the conditions set above in the company Modified Duty Policy. I also understand that the position being offered is a temporary position and is being offered to continue employment while I am recovering from this injury.

PLEASE CHECK ONE: ☐ I ACCEPT THIS POSITION BEING OFFERED ☐ I DECLINE THIS POSITION BEING OFFERED

EMPLOYEE SIGNATURE: _____ DATE: _____

INSURED REPRESENTATIVE SIGNATURE: _____ DATE: _____