WORKERS' COMPENSATION CLAIM KIT

Administrator

FutureComp®

Table of Contents

SECTION I

INTRODUCTORY LETTER

FutureComp®

Welcome,

We are pleased, on behalf of CBIA, to provide you with a copy of this FutureComp “Claim Kit”. Included, you will find step by step instructions for entering and reporting a claim, contact information for your dedicated Service Team, as well as a brief explanation regarding medical case management and other pertinent information to assist with the recovery of your employees.

At FutureComp, we look forward to working together with you to effectively manage your workers’ compensation needs.

If you have any questions or require further information, please let me know.

Sincerely,

Tony Szwez
Division Senior Vice President, FutureComp
(855) 874-0123 Ext. 7137504261

SECTION II

FUTURECOMP SERVICE TEAM

CBIA WORKERS' COMPENSATION SERVICE TEAM

Call Toll Free 855-874-0123 – Use Extension Numbers Listed

<table>
<tr><td>Todd R. Johnson, Administrator
President, FutureComp
Ext: 7813762682 / Cell: 508-572-0040
Email: Todd.Johnson@usi.com</td><td>Tony Szwez, Senior Vice President
Ext: 4137504261
Email: Tony.Szwez@usi.com</td></tr>
<tr><td colspan="2">Todd Kaupin
Vice President, Producer
Ext. 4137504289
Email: Todd.Kaupin@usi.com</td></tr>
<tr><td colspan="2">CLAIMS & MEDICAL CASE MANAGEMENT TEAM</td></tr>
<tr><td>Dianna Donnelly, Senior Claims Adjuster
Direct Line: 860-652-1095 / Fax: 484-652-5093
Email: Dianna.Donnelly@usi.com</td><td>Joanne Glenn, Claims Specialist II
Direct Line: 860-652-1059 / Fax: 610-537-2374
Email: Joanne.Glenn@usi.com</td></tr>
<tr><td>Fonda Carmody, Claims Supervisor
Direct Line: 860-652-1077 / Fax: 610-537-1912
Email: Fonda.Carmody@usi.com</td><td>Steve Grahn, Vice-President Claims Manager
Ext: 4137504250 / Fax: 413-739-9330
Email: Steve.Grahn@usi.com</td></tr>
<tr><td>Margery Thompson RN-BC, BSN, CCM
Nurse Case Manager
Ext. 2072393329 / Fax: 610-362-8689
Email: Margery.Thompson@usi.com</td><td>Lori Corso RN, BSN, CCM
Vice President Managed Care
Ext: 4137504256 / Fax: 610-537-9916
Email: Lori.Corso@usi.com</td></tr>
<tr><td colspan="2">Loss Run Requests - Email: FutureComp-WCSupport@usi.com</td></tr>
<tr><td>Sonja Cruz, Information Specialist
Ext: 4137504321 / Fax: 413-739-9330
Email: Sonja.Cruz@usi.com</td><td>Stefania Mahar, Technical Services Associate
Ext: 4137504216 / Fax: 413-739-9330
Email: Stefania.Mahar@usi.com</td></tr>
<tr><td colspan="2">Sarah Depergola, Vice-President & MIS Systems Reporting
Ext: 4137504273 / Fax: 413-739-9330
Email: Sarah.Depergola@usi.com</td></tr>
<tr><td colspan="2">LOSS CONTROL & TRAINING</td></tr>
<tr><td colspan="2">Robert Bolduc
Vice President, Loss Control
Ext. 8606521076
Email: Robert.Bolduc@usi.com</td></tr>
<tr><td colspan="2">530 Preston Avenue, 3rd Floor, Meriden CT 06450
FAX: (855) 874-1288</td></tr>
</table>

SECTION III

FUTURECOMP INJURY REPORTING INSTRUCTIONS

Reporting and First Report of Injury

There are a couple of different methods to report claims to FutureComp. The preferred method would be to input claims directly into the FutureComp Claims System. You also do have the ability to e-mail or fax an injury report to us.

- Entering claims via the **FutureComp Claims System**
  - Instructions on how to file a claim are located on pages 12-21
  - If you require a username and password, please contact:

Sarah Depergola
Vice-President & MIS Systems Reporting FutureComp
Tel: 413-750-4273 / Fax: 413-739-9330
Email: Sarah.Depergola@usi.com

Sonja Cruz
Information Specialist FutureComp
Tel: 413-750-4321 / Fax: 413-739-9330
Email: Sonja.Cruz@usi.com

- If submitting a claim via e-mail or fax (first report of injury can be found on pages 9-11), please send the information to:

Dianna Donnelly, Senior Claims Adjuster
Tel: 860-652-1095 / Fax: 484-652-5093
Email: Dianna.Donnelly@usi.com

Joanne Glenn, Claims Specialist II
Tel: 860-652-1059 / Fax: 610-537-2374
Email: Joanne.Glenn@usi.com

Fonda Carmody, Claims Supervisor
Tel: 860-652-1077 / Fax: 610-537-1912
Email: Fonda.Carmody@usi.com

*** Do not submit First Reports of Injury to the State of Connecticut**
FutureComp will file these electronically for you

SECTION IV

EMPLOYER'S FIRST REPORT OF INJURY FORM

When to File

File this form upon receipt of notice of any injury alleged to have occurred in the course of employment. This form is not an admission of liability. It must be filed even if you believe the employee is not injured or that the employee is not entitled to benefits.

Where to File

E-mail or fax to:

Dianna Donnelly, Senior Claims Adjuster
Fax: 484-652-5093
Email: Dianna.Donnelly@usi.com

Joanne Glenn, Claims Specialist II
Fax: 610-537-2374
Email: Joanne.Glenn@usi.com

Fonda Carmody, Claims Supervisor
Fax: 610-537-1912
Email: Fonda.Carmody@usi.com

State of Connecticut
Workers' Compensation Commission

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 3-17-2006

FRI

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

Date filed in Chairman's Office

(for WCC use only)

Employer *(Name, Address & Zip)* | Phone #

Carrier / Administrator Claim # | OSHA Log Case # | Report Purpose Code

Jurisdiction | Jurisdiction Claim #

Employer's Location Address *(if different)* | Phone #

SIC Code | FEIN -

Carrier *(Name, Address & Zip)* | Phone #

Claims Administrator *(Name, Address & Zip)* | Phone #

Policy / Self-Insured # | ❑ Check, if Self-Insured | Policy Period *(MM/DD/YY)* FROM: TO:

Employee: Last Name First Name Middle Name

Address *(incl. Zip)* | Phone #

Date of Birth *(MM/DD/YY)* | Social Security #

Gender ❑ Male ❑ Female

Date Hired *(MM/DD/YY)* | State of Hire e

Occupation / Job Title

Rate of Pay $ per ❑ Hour ❑ Day ❑ Week ❑ Bi-Weekly ☒ Other | NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)*

Time Employee Began Work ❑ a.m. ❑ p.m.

Time of Occurrence ❑ cannot be determined ❑ a.m. ❑ p.m.

Date Employer Notified *(MM/DD/YY)*

Date Disability Began *(MM/DD/YY)*

Date Last Worked *(MM/DD/YY)*

Date Return(ed) to Work *(MM/DD/YY)*

If Fatal, Date of Death *(MM/DD/YY)*

All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:

Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:

Contact Name

Phone #

Town of Injury / Illness

Did Injury / Illness occur on Employer's Premises? ❑ Yes ❑ No

Type of Injury / Illness

Part of Body Affected

Type of Injury / Illness Code

Part of Body Affected Code

Were Safeguards or Safety Equipment provided? ❑ Yes ❑ No

If provided, were they used? ❑ Yes ❑ No

How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:

Cause of Injury Code

Physician / Health Care Provider *(Name, Address & Zip)*

Hospital *(Name, Address & Zip)*

Initial Treatment

❑ No Medical Treatment ❑ Emergency Care

❑ Minor — by Employer ❑ Hospitalized More Than 24 Hours

❑ Minor — by Clinic / Hospital ❑ Future Major Medical — Lost Time Anticipated

Date Administrator Notified *(MM/DD/YY)* | Date Prepared *(MM/DD/YY)*

Preparer's Name & Title | Phone #

SECTION V

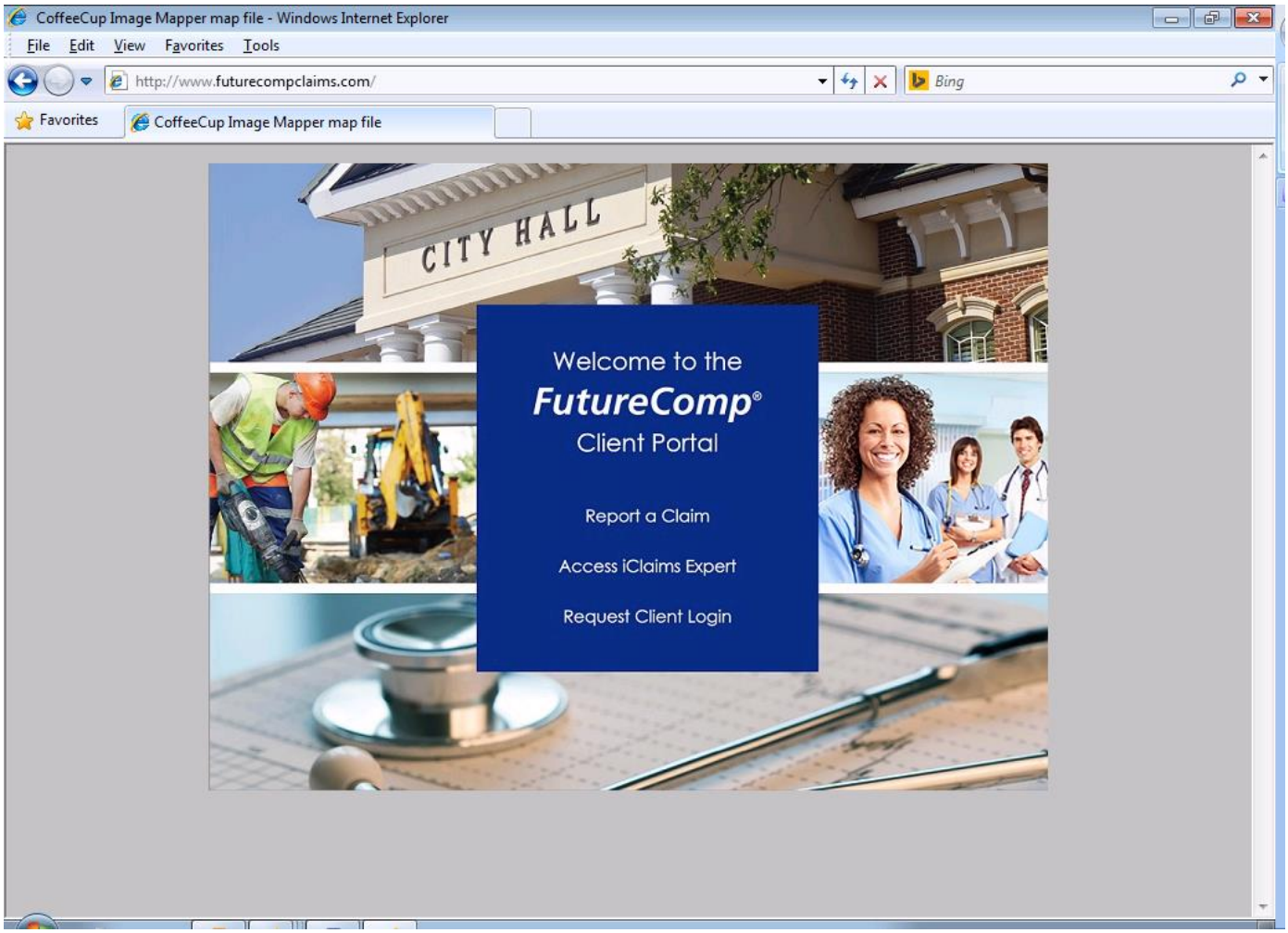
FUTURECOMP CLAIMS SYSTEMS

Accessing the Claims System from the Web

Copy and paste the web address to your browser and press Enter:

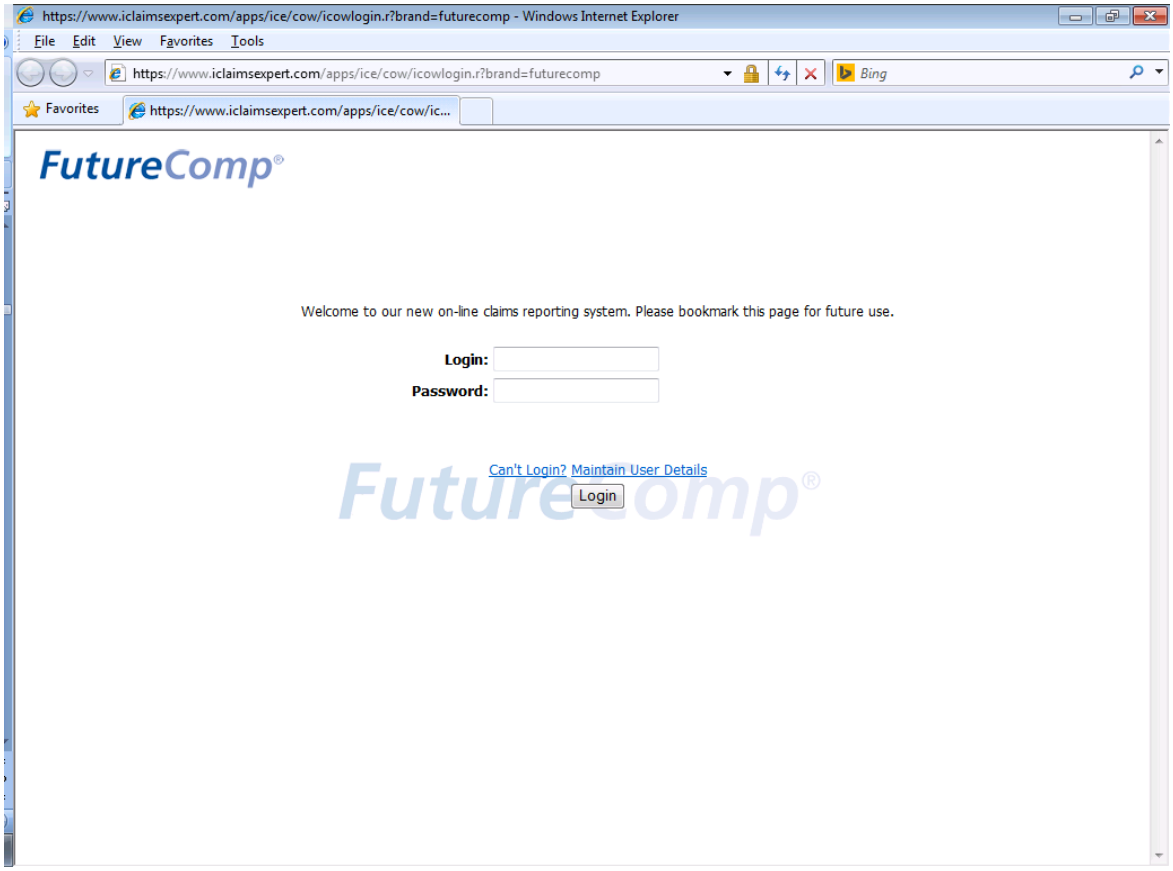
https://www.futurecompclaims.com

The following screen will appear.

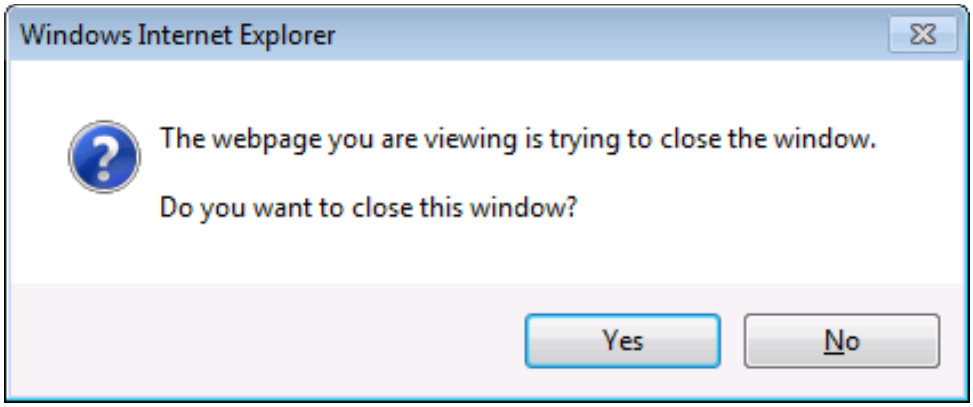


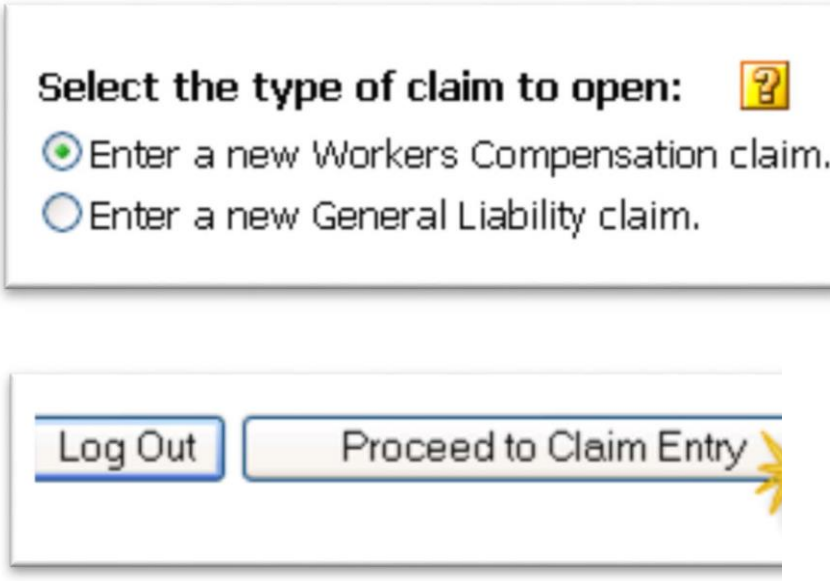
How to Report a Claim

Click on “Report a Claim” and enter in your “Login” name and “Password”.

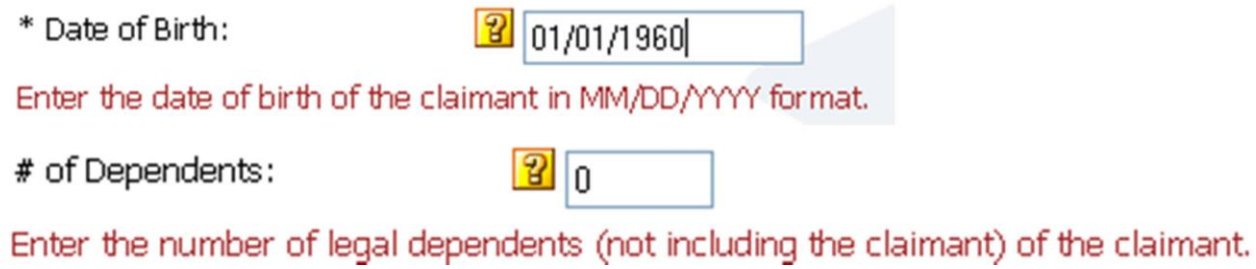


When you see this pop-up click “Yes”.





Click on a yellow question mark (?) button to view help on that data



field.

An asterisk (*) indicates required information

Input dates and times in the following formats:

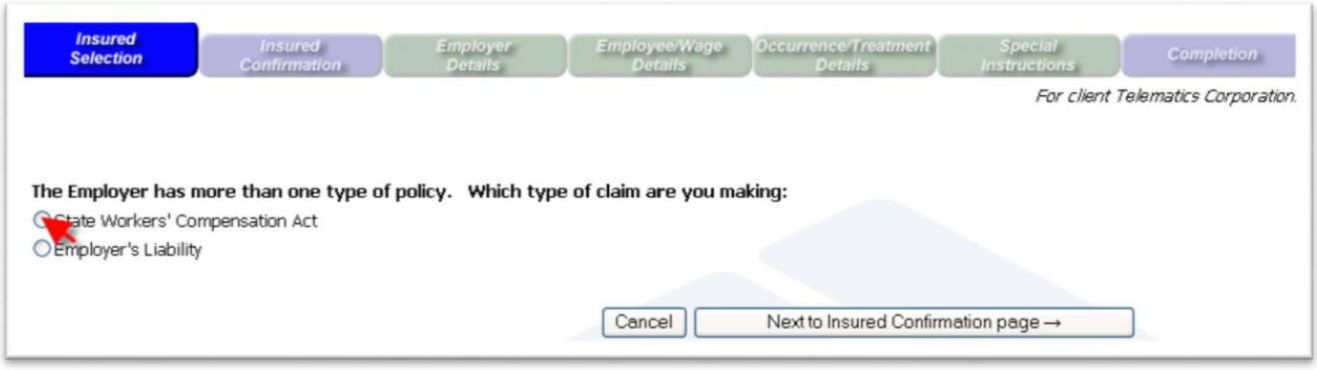
Dates: 01/01/2001 or 01/01/2001 or 01012001

Times: 09:00 (select AM or PM)

Reporting a Workers Compensation Claim

Insured Selection

In this example, choose “State Workers’ Compensation Act”



Reporting a Workers Compensation Claim

Insured Confirmation

The Insured Confirmation page confirms that you are opening a Workers Compensation claim:

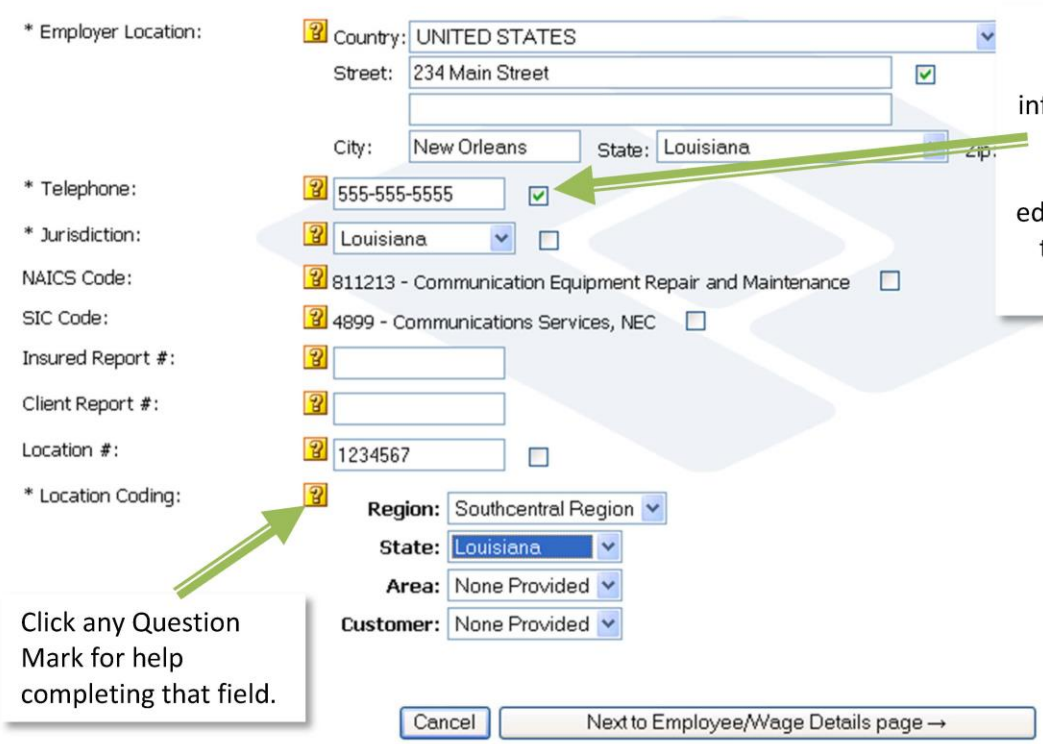
.

Reporting a Workers Compensation Claim

Employer Details

Insured Selection | Insured Confirmation | Employer Details | Employee/Wage Details | Occurrence/Treatment Details | Special Instructions | Completion

For client Telematics Corporation.



Check the box next to a selection and the identical information will auto-populate each time you input a new claim. The field will remain editable; check the box to save time and change it when you need to.

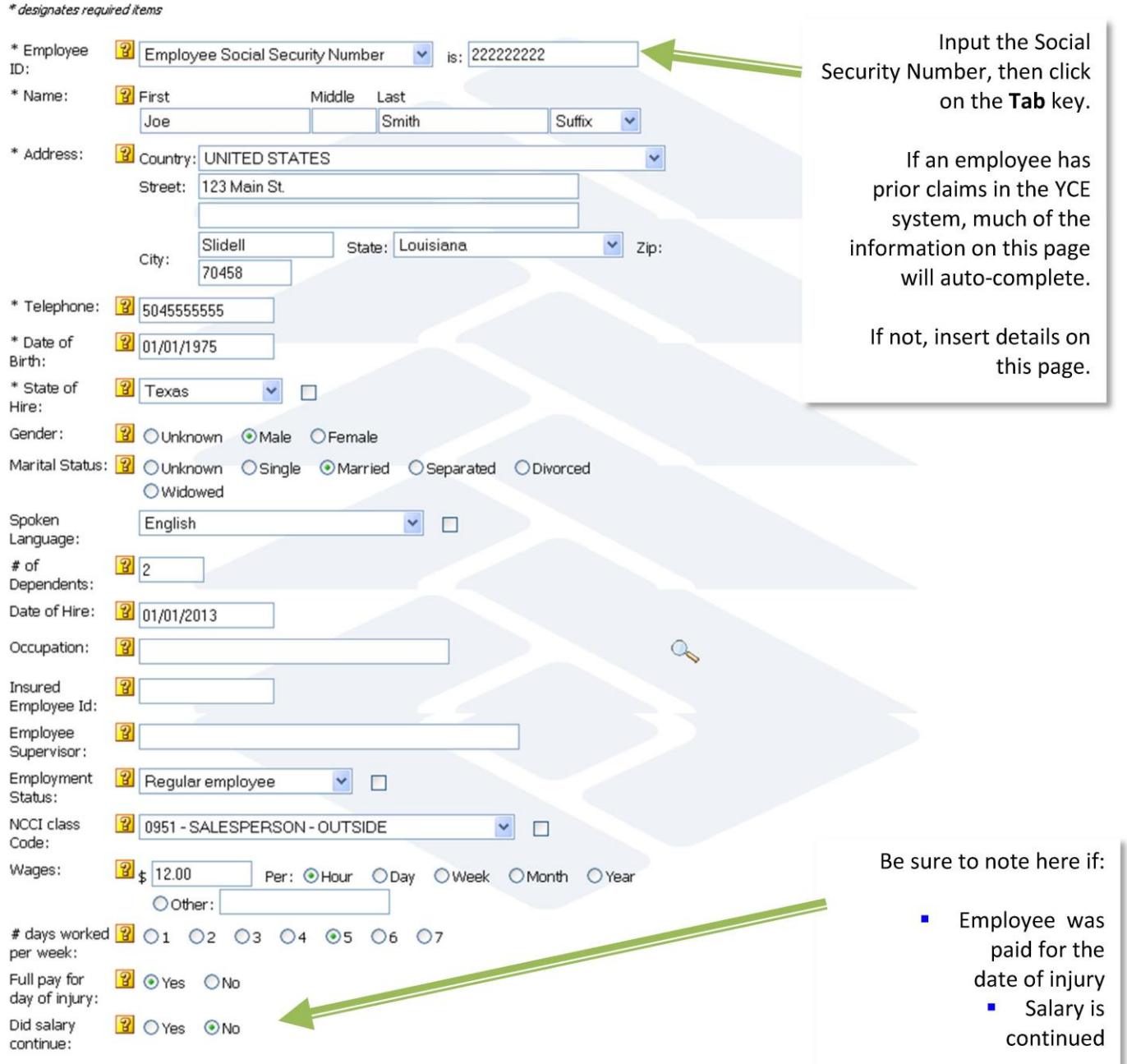
Click any Question Mark for help completing that field.

At the bottom of each screen, click "Next" to continue.

Employee/Wage Details

Insured Selection | Insured Confirmation | Employer Details | Employee/Wage Details | Occurrence/Treatment Details | Special Instructions | Completion

For client Telematics Corporation.



Input the Social Security Number, then click on the **Tab** key.

If an employee has prior claims in the YCE system, much of the information on this page will auto-complete.

If not, insert details on this page.

Be sure to note here if:

- Employee was paid for the date of injury
- Salary is continued

← Back to Employer Details page | Cancel | Next to Occurrence/Treatment Details page →

Reporting a Workers Compensation Claim

Occurrence/Treatment Details

Insured Selection | Insured Confirmation | Employer Details | Employee/Wage Details | Occurrence/Treatment Details | Special Instructions | Completion

For client Telematics Corporation.

* designates required items

Be sure to use the correct format for **Date** (01/01/2001, 01-01-2001, or 01012001) and **Time** (09:00)

Employee began work: ( ) AM ( ) PM

* Date of accident: 05/15/2013 * Time: 09:00 (•) AM ( ) PM

* Did injury cause death: ( ) Yes (•) No If yes, give date of death:

* Date employer notified: 05/15/2013 * Time: 09:30 (•) AM ( ) PM

* Nature of injury: Specific Injury Concussion

* Part of body: Head Skull

* Cause of injury: Fall, Slip, or Trip Injury On Ice or Snow

* How accident occurred: Employee was walking into building from car (returning from meeting with client) and slipped on ice outside main entrance, landing on back and hitting head.

* Where accident occurred: Did injury/illness exposure occur on employer's premises: (•) Yes ( ) No

Specify the department or location on the premises: outside main entrance

* State of Accident: Texas

Doing usual work: (•) Yes ( ) No

Contact Name:

	First	Middle	Last	
Title	Walter		Jones	Suffix

Telephone: 222-222-2222

Equipment, materials or chemicals involved: None.

Specific activity engaged in when occurred: Walking into building from parking lot.

Work process engaged in when occurred: Returning from meeting with client.

Safeguards provided: ( ) Yes (•) No

Safeguards used: ( ) Yes (•) No

Witnesses:

	First	Middle	Last		Phone
Title				Suffix	
Title				Suffix	

Date last worked: 05/15/2013

Date disability began: 05/16/2013

Date returned to work:

Initial treatment:
- ( ) No medical treatment
- ( ) Minor: by employer
- ( ) Minor: by clinic or hospital
- ( ) Emergency care
- ( ) Hospitalized > 24 Hrs.
- (•) Future major medical / Lost Time anticipated

Physician/Health Care provider:

	First	Middle	Last	
Title	John		Smith	Suffix

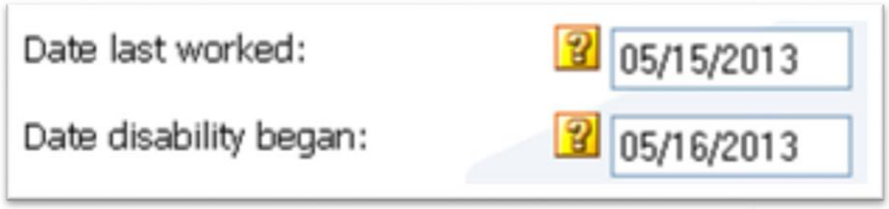
Country: UNITED STATES
Street: 123 High Street
City: Slidell State: Louisiana Zip: 70458

Hospital:
Name:
Country: UNITED STATES
Street:
City: State: Select State Zip:

← Back to Employee/Wage Details page | Cancel | Next to Special Instructions page →

Reporting a Workers Compensation Claim

Occurrence/Treatment Details



Reporting a Workers Compensation Claim

Special Instructions

For client Telematics Corporation.

Almost finished! Please tell us if you have any special instructions. These items are not shown on the first report of injury.

** designates required items*

* Send first report of injury to: lisa.sudbury@yorkrsg.com

Note: You may enter multiple email addresses seperated by commas

Contact me first: Check this box to alert the adjuster to contact you prior to any investigation.

Any message for the adjuster: Place a message for the claims examiner here.

Would you like an investigator involved:

Based upon the information provided, a new Indemnity claim will be opened momentarily. If you believe that this is an incorrect decision, change this decision now by selecting one of: No Change

This is your last chance, press "Cancel" now if you want to abandon this claim opening. Otherwise, press "Next to Completion page" to submit the claim and generate the first report of injury.

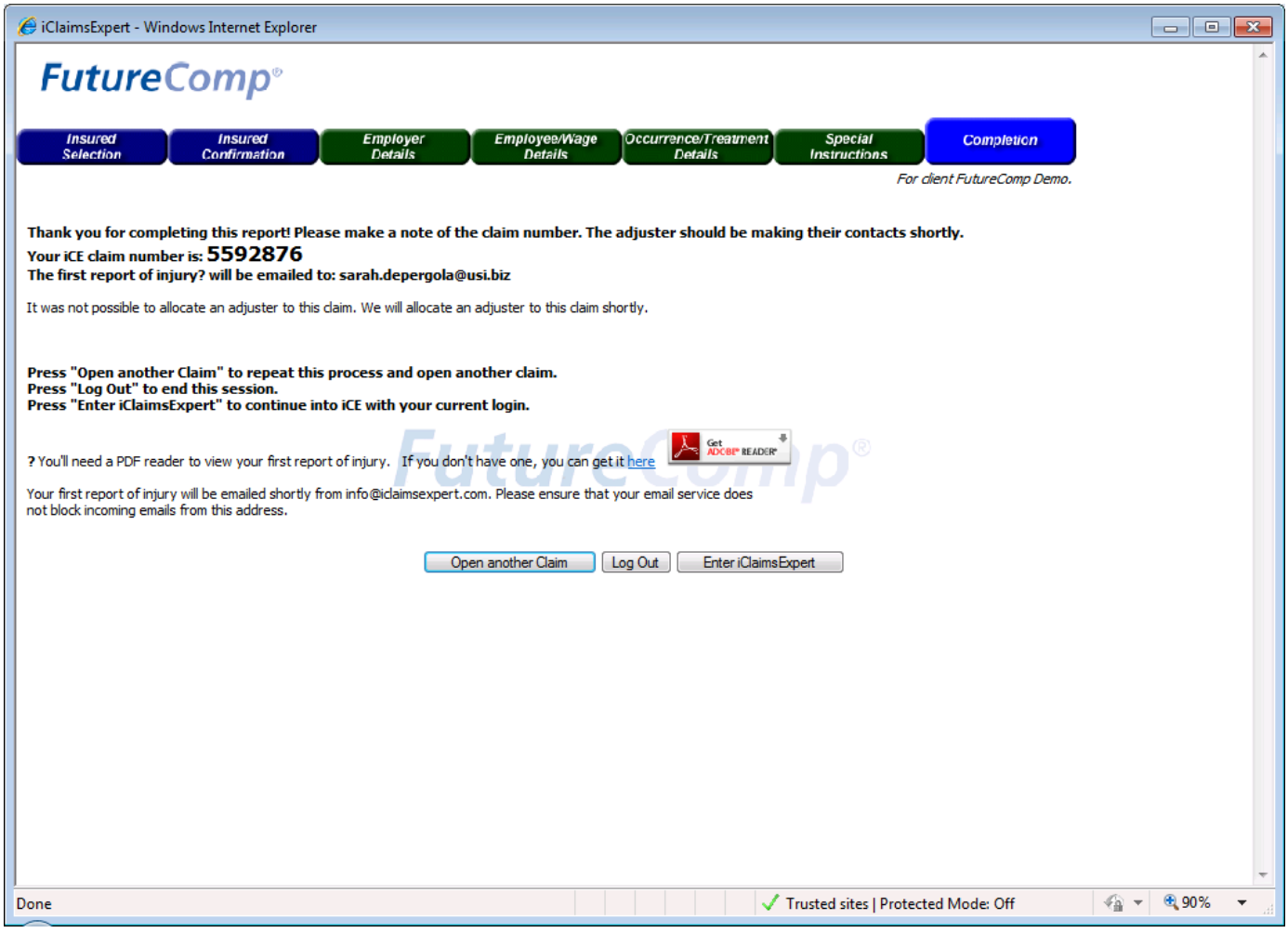
← Back to Occurrence/Treatment Details page | Cancel | Next to Completion page →

At this point, you have 3 choices:

Open another Claim, Log Out or Enter iClaimsExpert.

If you select Enter iClaimsExpert

it will bring you into the claims system.



SECTION VI

MEDICAL CASE MANAGEMENT

MEDICAL CASE MANAGEMENT

Case Management is a collective process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes." (Case Management Society of America. What is a case manager? 2017)

The nurse works collaboratively with all stakeholders to provide clinical expertise, effective communication and problem solving to help establish the best plan of care and provide clinical oversight to help injured employees return to work as quickly and safely as possible.

The underlying premise of FutureComp case management is that when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individual being served, their support system, the health care delivery system and the reimbursement sources or payers.

The goals of Medical Case Management are:

- Assist the employee to achieve an optimal level of wellness and function by facilitating timely and appropriate health services.
- Facilitate early return-to-work through transitional/light duty return-to-work programs.
- Assure appropriateness of treatment.
- Assure appropriate duration of treatment.
- Through communication and consultation with claim adjusters facilitate appropriate expenditure of claims and timely claim determinations.
- Channel injured workers to their approved Preferred Provider Network providers when appropriate.
- To assure that the injured worker receives quality, cost effective medical care.
- Enhance employee productivity, satisfaction and retention.

- **Medical Case Management consists of the following steps:**
- Information gathering
- Assessment/Problem identification
- Rehabilitation plan development/Goal setting
- Rehabilitation plan implementation
- Ongoing and timely reporting
- Rehabilitation plan follow through and outcome assessment

SECTION VII

WAGE STATEMENT FORM

Wage Statement Form

When to File

File this form as soon as you know that the injured employee will be absent one or more days from work. This form is used to calculate the injured employee's average weekly compensation.

Where to File

E-mail or fax to:

Dianna Donnelly, Senior Claims Adjuster
Fax: 484-652-5093
Email: Dianna.Donnelly@usi.com

Joanne Glenn, Claims Specialist II
Fax: 610-537-2374
Email: Joanne.Glenn@usi.com

Fonda Carmody, Claims Supervisor
Fax: 610-537-1912
Email: Fonda.Carmody@usi.com

WAGE STATEMENT

CLAIM NO.:

EMPLOYER NAME AND ADDRESS:	EMPLOYEE NAME:
	JOB TITLE:
DATE OF INJURY:	SOCIAL SECURITY NO.:
DATE OF DISABILITY:	DATE OF HIRE:
RETURN TO WORK DATE (if any)	DATE OF THIS STATEMENT

Indicate below gross wages, including overtime, for 52 calendar weeks prior to the accident. If employee worked less than 52 weeks, give wages from date he/she entered employment. If employee worked less than 2 calendar weeks, provide weekly earnings of a similar worker in the same class of employment who has worked for one year or more.

Week No.	Year: Week Ending Month	Day	Gross Amount Paid Including Overtime	Week No.	Year: Week Ending Month	Day	Gross Amount Paid Including Overtime	Week No.	Year: Week Ending Month	Day	Gross Amount Paid Including Overtime
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				24				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35				TOTAL			
18				36							

Was this employee given free rent, lodging, board, tips, bonus or other allowance in addition to the above earnings [ ] Yes [ ] No	If yes, state weekly value thereof and describe $ _____

I CERTIFY THAT THE ABOVE IS A TRUE COPY OF THE PAYROLL RECORD OF THE ABOVE NAMES EMPLOYEE OR AN EMPLOYEE IN THE SAME CLASS OF EMPLOYMENT

Name of Fellow Employee	Employer Preparer's Signature	Preparer's Title

SECTION VIII

STATE OF CONNECTICUT FILING STATUS AND EXEMPTION FORM

State of Connecticut
Filing Status and Exemption Form

When to File

File this form as soon as you know that the injured employee will be absent one or more days from work. This form is used with the Wage Statement Form to calculate the injured employee's compensation.

Where to File

E-mail or fax to:

FutureComp

Dianna Donnelly, Senior Claims Adjuster
Fax: 484-652-5093
Email: Dianna.Donnelly@usi.com

Joanne Glenn, Claims Specialist II
Fax: 610-537-2374
Email: Joanne.Glenn@usi.com

Fonda Carmody, Claims Supervisor
Fax: 610-537-1912
Email: Fonda.Carmody@usi.com

State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 7-13-2009

1A

Filing Status and Exemption

This form must be executed in every case of compensable disability for injuries occurring ON OR AFTER October 1, 1991, and must be completed in its entirety.

WCC File #

Date filed in District

(for WCC use only)

EMPLOYEE

Name _____ Date of Birth *(required)* _____

Address _____

City/Town _____ State _____ Zip Code _____

DATE OF INJURY:

_____

FILING STATUS AND EXEMPTIONS — In order to determine your weekly benefit rate, as per Sec. 31-310 C.G.S.,we need the following information:

1. Select your Federal tax filing status based upon your **ACTUAL filing status as of the date of injury**, listed at right: *(Must match your tax return, as if you were filing with the IRS on the date of your injury.)*

   ❑ Single ❑ Head of Household ❑ Married filing jointly ❑ Married filing separately

2. Number of exemptions *(including yourself)* as of the date of injury listed at right = _____

3. FICA withheld for the above-named employee? ..... ❑ YES ..... ❑ NO — ***If NO, insurer must manually calculate weekly benefit rate.***

4. Check all appropriate boxes:

   ❑ Employee 65 years of age or older ❑ Employee legally blind ❑ Spouse 65 years of age or older ❑ Spouse legally blind

5. List name *(yourself first)*, date of birth, and relationship to you for all exemptions included in question #2, above:

Name	*Date of Birth*	*Relationship*
		SELF

CONCURRENT EMPLOYMENT — To be certain you receive all the benefits to which you are entitled, provide the following information *if you were working for more than one employer on the date of injury indicated above*:

Name of Employer	*Address*	*Date of Hire*

NOTE: Wage information for each concurrent employer must be supplied by the claimant.

SIGNATURE OF INJURED WORKER OR REPRESENTATIVE

I hereby attest that the above information is correct to the best of my knowledge.

Employee's Signature _____ Date _____

SECTION IX

STATE OF CONNECTICUT
MEDICAL AUTHORIZATION FORM

STATE OF CONNECTICUT
WORKERS' COMPENSATION COMMISSION

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS BY A HOSPITAL/PROVIDER FOR THE PURPOSE OF ADMINISTERING A CONNECTICUT WORKERS' COMPENSATION CLAIM FOR BENEFITS

PATIENT NAME: _____ DATE OF BIRTH: _____
(PLEASE PRINT NAME) (REQUIRED)

BODY PART(S): _____

I, the undersigned, authorize: _____
(HOSPITAL/PROVIDER)

to disclose, in writing, protected health information [PHI] to:

_____
(PERSON OR ENTITY TO WHOM INFORMATION IS TO BE DISCLOSED)

and its attorneys and/or representatives. The PHI to be disclosed is relevant medical records and reports relating to my medical treatment/consultation/examination and/or diagnostic procedures performed at the above-named medical facility and which pertain to an injury/occupational disease for which I am claiming benefits under the Connecticut Workers' Compensation Act. I understand the information disclosed based on this authorization may include mental health treatment records and information regarding HIV/AIDS status, treatment or testing. **INFORMATION RELATING TO TREATMENT FOR ALCOHOL AND DRUG ABUSE WILL NOT BE RELEASED WITHOUT MY SPECIFIC CONSENT in accordance with state and federal law**.[1] I understand I have the right to inspect or copy the PHI to be disclosed as permitted under federal HIPAA law and state law.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION. In order to revoke this authorization I may, at any time, send written notification to the above-named HOSPITAL/PROVIDER. I understand that my revocation of this authorization is ineffective to the extent that the above-named HOSPITAL/PROVIDER has relied on this authorization to disclose PHI relating to me.

I UNDERSTAND THAT PHI DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE PERSON OR ENTITY I HAVE IDENTIFIED ABOVE AND MAY NO LONGER BE PROTECTED FROM DISCLOSURE TO OTHERS BY FEDERAL OR STATE LAW. I understand that the above-named HOSPITAL/PROVIDER may not condition my treatment on whether I provide authorization for the requested use or disclosure.

I UNDERSTAND THAT I HAVE THE RIGHT TO DETERMINE A DATE OR EVENT AT WHICH TIME THIS AUTHORIZATION EXPIRES. I am identifying the expiration date of this authorization to be COMPLETION OF WORKERS' COMPENSATION LITIGATION AS EVIDENCED BY A STIPULATION OR FINDING AND AWARD/DISMISSAL, OR IN THE EVENT OF APPELLATE REVIEW, A FINAL DETERMINATION BY THE HIGHEST APPELLATE AUTHORITY TO WHOM AN APPEAL IS MADE.

I further understand that federal HIPAA law does not require me to provide an authorization in this form as the purpose of this authorization relates to a Workers' Compensation matter. However, I understand that as a practical matter, my authorization in this form may facilitate the processing and administration of my claim for Workers' Compensation benefits.

My signature below indicates that I have read and understand this Authorization and its terms.

_____ _____

Signature of Patient Date

[1] Any consent to release information pertaining to treatment for drug and alcohol abuse must conform to the requirements of state law and the federal regulations, e.g., Part 2 of Title 42 of the Code of Federal Regulations.

SECTION X

MILEAGE WORKSHEET

Mileage Worksheet for Medical Treatment — Examination — Physical Therapy — Laboratory Test

[Section 31-312 C.G.S.]

Rev. 3-17-2006

Employee Name _____ Date of Injury _____ Claim # _____

(Please TYPE or PRINT IN INK)

Employer Name _____

DATE: Month / Day / Year	FROM: City / Town , State	TO: City / Town , State	REASON FOR VISIT — NAME OF PHYSICIAN or Other Health Care Provider	ROUND-TRIP MILEAGE:
____/____/____				
____/____/____				
____/____/____				
____/____/____				
____/____/____				

DATE SUBMITTED _____ **TOTAL MILEAGE =** _____

SECTION XI

STATE OF CONNECTICUT
EMPLOYEE AND MEDICAL WORK STATUS FORM

Workers' Compensation — Employee Medical & Work Status Form

Rev. 9-26-2011

To Be Completed by Attending Physician/Office

Give a copy to employee at time of visit ■ File a copy in medical file
Fax a copy to carrier, TPA, employer, or designee within one business day of visit

Employee Name: _____ Date of Birth: _____ / _____ / _____
(last) (first) (middle)

Employer Name: _____ Department/Division: _____

Employer Address/Location: _____

Initial or *Follow-Up* Visit (circle one) Payer/Managed Care Plan Name: _____ Claim#: _____

Date of Injury/Illness: _____ / _____ / _____ Date of this visit: _____ / _____ / _____ ❑ Employee will be seen in this office for

Employee's job (as stated by employee): _____ follow-up on _____ / _____ / _____ .

WORK STATUS - Having evaluated/treated this employee today, in my opinion:

❑ Employee may continue regular work duty. ❑ There is **no change from prior visit**.

❑ Employee may return to his/her regular work on _____ / _____ / _____ without restriction.

❑ Employee can return to work on _____ / _____ / _____ with the **following functional capabilities**: In an 8-hour workday, employee may:

	1-2 hours	2-4 hours	4-6 hours	6-8 hours	None
Stand	❑	❑	❑	❑	❑
Walk	❑	❑	❑	❑	❑
Sit	❑	❑	❑	❑	❑
Bend/Squat	❑	❑	❑	❑	❑
Climb	❑	❑	❑	❑	❑
Reach	❑	❑	❑	❑	❑
Twist	❑	❑	❑	❑	❑
Crawl	❑	❑	❑	❑	❑
Drive	❑	❑	❑	❑	❑
Foot/Feet	❑	❑	❑	❑	❑
Hand(s)	❑	❑	❑	❑	❑

❑ Patient is able to lift ❑ Patient is **unable to lift greater than** _____ **pounds**.

Patient may use ❑ RIGHT ❑ LEFT ❑ BOTH foot/feet for repetitive movement as in operating foot controls.

Patient may use ❑ RIGHT ❑ LEFT ❑ BOTH hands for repetitive ❑ single grasping ❑ fine manipulation ❑ pushing and pulling.

The restrictions noted above are in effect until _____ / _____ / _____ .

❑ Employee is Temporarily Totally Disabled until _____ / _____ / _____ or pending recheck here on _____ / _____ / _____ .

❑ Employee is on medication that will restrict his/her ability to work safely. Explain: _____

_____

I HAVE DISCUSSED THIS PATIENT'S WORK RESTRICTIONS TELEPHONICALLY TODAY WITH HIS/HER EMPLOYER'S REPRESENTATIVE, OR HAVE COMPLETED THE EMPLOYER'S WORK STATUS FORM IN LIEU OF COMPLETING THE RESTRICTION PORTION OF THIS FORM. RELEASE TO REGULAR DUTY WITHOUT RESTRICTIONS AND/OR TOTAL DISABILITY MUST BE DOCUMENTED USING THIS FORM OR THE EMPLOYER'S STANDARD FORM.

DIAGNOSIS: _____ **TREATMENT PLAN:** _____

_____

Provider Name (print): _____ Provider Address: _____

Provider Signature: _____ Date: _____ / _____ / _____

I have received a copy of this document—Employee Signature: _____ Date: _____ / _____ / _____

SECTION XII

myMATRIXX PHARMACY NETWORK

Workers' Compensation Temporary Prescription ID Card

myMatrixx
An Express Scripts Company

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed up the processing of your approved workers' compensation prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the Patient Care Contact Center at 800.945.5951.

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame al Centro de Contacto para Atención a Clientes de Express Scripts, al 800.945.5951.

ID#: _____

Your SSN is your temporary ID number, present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____/_____/_____
MM/DD/YYYY

Group #: NX5A

Employee Date of Birth: _____/_____/_____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Pharmacist:

myMatrixx, an Express Scripts company administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 15-day supply or a cost of $300. (Note: the limit on post exposure prophylaxis is $3,000). This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call Express Scripts at 888.786.9640.

Pharmacy Processing Steps

Step 1: Enter BIN number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

FutureComp

Participating Retail Network Pharmacies

myMatrixx
An Express Scripts Company

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target/CVS
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Walmart
Wegmans
Weis
Winn Dixie

FutureComp Quick Reference Guide

myMatrixx
An Express Scripts Company

Who is myMatrixx?

myMatrixx is an industry-leading pharmacy benefit manager for work-related injury claims. Some features/benefits of the FutureComp prescription program include:

- Availability to all employees injured at work
- Access to a nationwide network of more than 70,000 pharmacies
- Significant savings beyond fee schedule
- Immediate claim adjudication
- Contact center and pharmacy support, as well as availability of a registered pharmacist, 24 hours a day, 7 days a week

Core Components of the FutureComp Prescription Program

1) **First Fill Program** – Offers up to a 15-day supply of medication to the injured worker at the time of injury. The employer gives the employee a temporary ID card form, which provides a listing of participating pharmacies and instructions to assist those pharmacies with processing any medications.

2) **Retail Program** – The injured worker receives a prescription-drug ID card from myMatrixx based on the eligibility provided by Medata. The card is valid only for medications related to the work injury, and the injured worker may use the card at any network pharmacy. The injured worker also receives a courtesy phone call notifying the injured worker the card is in the mail and encourage the use of a network pharmacy.

3) **Home Delivery** – myMatrixx can fill up to a 90-day supply of medication for injured workers through Home Delivery from the Express Scripts Pharmacy. To request that an injured worker be contacted to convert to Home Delivery, please contact the Mail Conversion Center at 1.866.533.6227.

4) **Formulary and Prior Authorization** – In consultation with a myMatrixx clinical pharmacist, and in compliance of state regulations, FutureComp selected the most appropriate formulary(ies) for their pharmacy program. The formulary covers certain medications based on the acute, sub-acute and chronic phases of the claim life cycle. Note: Any state with a mandated formulary will be enforced on all applicable claims based on claim's state of jurisdiction.
   - If a medication is on the formulary, it is not necessary to contact myMatrixx in advance for approval.
   - However, if a medication is not on the formulary and should require authorization for a specific claim, myMatrixx will notify the adjuster/claims examiner for appropriate approval.

WORKERS' COMPENSATION

Contact Center:
Card requests, pharmacy assistance, new claims, eligibility updates and medication approvals, etc.

24 hours a day, 7 days a week
1.800.945.5951

Mail Conversion Center:
Provides support transitioning patients to the Express Scripts Home Delivery pharmacy.
M-TR, 7:30 a.m. – 5:30 p.m., CDT
F, 7:30 a.m. – 5:00 p.m., CDT
1.866.533.6227
WorkCompMCC@Express-Scripts.com

Clinical Pharmacist Support:
Provides support regarding formulary, therapy, and other drug-related inquires.
ConsultRx@Express-Scripts.com

Account Manager:
Provides support for all reporting and program related inquires.
Michael Harley
mharley@mymatrixx.com
813.521.4259

Account Executive:
Jason Storner
jstorner@mymatrixx.com
314.692.4167

RESEARCH-DRIVEN SOLUTIONS.
PROVEN PHARMACY RESULTS.

FutureComp Quick Reference Guide

myMatrixx
An Express Scripts Company

FutureComp Billing Information

This information can be provided directly to the patient or pharmacy, in the event that they do not have the correct billing information.

Bin Number - 003858
Control Number - WC
Rx Group Number -NX5A
Member Number -Claim Number
DOI Field - Date of Injury (in YYYYMMDD)

Note: If a claim number is not available (new claim) the patient's SSN can be used to facilitate processing of the medication.

myPassport Authorization Tool

- To set up a new user with access, email accountmanagement@myMatrixx.com
- If you forget your password, please utilize the forgot password link in the login page

Frequently Asked Questions

Q: Who can I contact if I have questions on drug to drug interactions, drug uses, or formulary questions?
A: E-mail our Clinical Team at ConsultRx@express-scripts.com

Q: What is the process if I decide to reverse a decision on a medication (e.g. if I deny the medication and later decide to accept it)?
A: You should contact the Contact Center at retailcard@express-scripts.com or 1.800.945.5951

Q: What if I need request assistance accessing the myPassport portal?
A: Contact the accountmanagement@mymatrixx.com

Q: How can I set up an injured worker on Home Delivery?
A: Contact the Mail Order Conversion Department at WorkCompMCC@express-scripts.com or call 1.866.533.6227

Q: Who can the injured worker reach out to if they need to check the status of, or re-order Home Delivery medications?
A: Call the Contact Center at 1.800.945.5951

Q: Who can I reach out to should I have a question or concern about the Express Scripts Pharmacy Program?
A: Contact your Account Manager, Michael Harley at 813.521.4259 or mharley@mymatrixx.com

Q: How do I obtain transaction history for a patient?
A: Transaction history can be exported via the transactions tab in the myPassport portal. You may also email accountmanagement@myMatrixx.com

Q: What if a patient needs a new pharmacy card?
A: Contact retailcard@express-scripts.com. Cards may also be requested via the "Send Card" feature on the eligibility tab in the myMatrixx portal

WORKERS' COMPENSATION

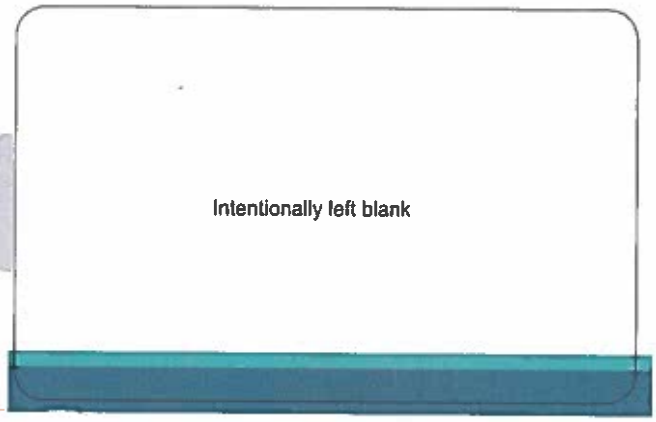
For injured worker questions:
Call the Contact Center

24 hours a day, 7 days a week
1.800.945.5951

RESEARCH-DRIVEN SOLUTIONS.
PROVEN PHARMACY RESULTS.

FutureComp FUTURECOMP
711 E MAIN ST STE 201
CHICOPEE, MA 01020
NX6

myMatrixx
An Express Scripts Company



2019999999 - 000000001 CID PMM-CWK

JOHN Q SAMPLE
123 ANYSTREET
APT. 456
SOMETOWN, US 99999-9999

00101010000066666660

Your Workers' Compensation Prescription ID Card

FutureComp has chosen myMatrixx, an Express Scripts company to manage your Workers' Compensation pharmacy program. Attached above is your prescription ID card that you can use immediately at an in-network pharmacy for your work-related injury or illness. By using your prescription ID card at an in-network pharmacy you won't pay up front or need to submit reimbursement requests to FutureComp.

In-Network Pharmacies Located Near You

Here is a partial list of in-network pharmacies located close to the address we have on file for you. For additional pharmacy locations, go to www.myMatrixx.com and click on Pharmacy Search or call the customer care number on the backside of your pharmacy card.

*This list is subject to change without notice

Pharmacy1Name
Pharmacy1Addr1
Pharmacy1Addr2
P1City, S1

Pharmacy2Name
Pharmacy2Addr1
Pharmacy2Addr2
P2City, S2

Pharmacy3Name
Pharmacy3Addr1
Pharmacy3Addr2
P3City, S3

Protection from Unsafe Drug Interactions

It is important to fill your prescription through an in-network pharmacy rather than receiving medication directly through your doctor because it does not go through the customary safety checks provided at a pharmacy. A pharmacist provides oversight and knows about all medications you may be taking as well as your medical history. This can help protect you against unsafe drug interactions.

Sign Up for Home Delivery

myMatrixx utilizes the Express Scripts Pharmacy to provide home delivery of medications for greater convenience, service and safety. The benefits of home delivery are:

- Get a 90-day supply conveniently by mail
- Delivered to your home with free standard shipping
- Easy refills online, phone or mail

To sign up for home delivery, call myMatrixx today at 800.945.5951.

IIWCI02F LTR 01/2019

Questions?
Call myMatrixx at 800.945.5951, 24/7.

SECTION XIII

FREQUENTLY ASKED QUESTIONS

How Can We Help You … Please Call Us.

The 10 Most Frequently Asked Questions

1. Does the injury information form need to be completed in its entirety?

There is minimal information that needs to be completed for a claim to begin the process and receive a claim number. The adjuster will gather the remaining portion of information during the investigation process.

2. How are lost wages calculated when an employee is out of work?

When an injured employee is totally disabled from working, their benefits will be based on 75% of the gross (pre-tax, pre-benefits) average weekly wage for the 52 weeks prior to date of injury. When paid, these wages are also exempt from taxes.

3. I am approved to receive claim reports, who do I call for them?

Loss run information or any customized report request should be directed to:

Sarah Depergola
Vice-President & MIS Systems Reporting FutureComp
Tel: 413-750-4273 / Fax: 413-739-9330
Email: Sarah.Depergola@usi.com

Sonja Cruz
Information Specialist FutureComp
Tel: 413-750-4321 / Fax: 413-739-9330
Email: Sonja.Cruz@usi.com

4. Is it all right to fax/email first reports of injury?

While the preferred method of reporting a claim is directly into the FutureComp claims system via the web portal; yes, fax/email is an acceptable manner of reporting a claim to FutureComp. The first report of injury needs to arrive in an expeditious manner allowing FutureComp to begin the claims process. We would enter the claim on your behalf.

5. What information is needed to pay a medical bill?
Two things are needed, an itemized bill and a medical report. If the bill is a balance forward or there is no medical report attached, the bill is sent back to the provider requesting proper information.

6. When mailing claims information or medical bills who should we send them to?
All information regarding workers' compensation claims should be directed to FutureComp:

FutureComp
530 Preston Avenue, 3rd Floor
Meriden, CT 06450

7. When are Indemnity/Medical/Expense reimbursements mailed?
Checks are mailed every Thursday.

8. Do injured employees get reimbursed for mileage?
Yes, the injured employee is paid the Federal mileage reimbursement rate that is in place at the time.

9. How quickly does a new injury need to be reported?
All injuries need to be reported immediately. The sooner FutureComp receives the claims information, the sooner we begin the investigation. The more time that lapses in the reporting of a claim the less information can be gathered.

10. Are injured employees entitled to any benefit for permanent partial disability due to work related injuries?
The amount of remuneration depends on type and extent of loss.

If there are any questions regarding your program, please do not hesitate to contact us.