Workers' Compensation

Claims Reporting Packet

MATRIX OneSource
A Vensure Employer Solutions Company

Contents

Workers' Compensation Claim Protocols

CLAIM MANAGEMENT PHILOSOPHY

At MatrixOneSource, we have a unique, yet simple philosophy. We believe that no two claims are the same and each claim should be handled as a unique and individual situation. Therefore, we believe that through diligence and innovative thinking we can impact each claim to reduce costs and disruption of workforce. We accomplish this through a multifaceted approach with our claims oversight and encourage Clients' participation in the claims handling process.

CLAIMS SPECIALIST

Each MatrixOneSource Client is assigned a dedicated Claims Specialist. The role of the Claims Specialist is to act as a liaison between MatrixOneSource's clients, injured workers and the respective insurance carrier responsible for adjudicating the clients workers' compensation claims to ensure claims are handled in a timely manner with the best possible outcome. The Claims Specialist is the primary contact for claim specific information at MatrixOneSource.

CLAIMS REPORTING

The single most important factor in the handling of Workers' Compensation Claims is time. Time dictates everything from statutory guidelines to proper investigation. With that in mind, MatrixOneSource requires our Clients to report any and all work-related incidents to the Claims Department within 24 hours of their knowledge of the incident.

Incidents are defined as any episode in which one or more employees are involved in any situation in which an injury of any kind has occurred or could have occurred. This is inclusive of all injuries in which medical treatment was not sought or was rejected. In our experience, even injuries in which an employee refuses medical treatment has a potential to later become an active claim.

RETURN TO WORK

MatrixOneSource is an advocate of introducing employees back into the workforce at a speed and level at which they are medically able to do so. Additionally, this approach improves your loss history, ultimately resulting in lower premium costs. MatrixOneSource requires that all Clients make reasonable and necessary accommodations that may be required to return an injured employee to a modified work position commensurate with the temporary work restrictions authorized by the treating physician. Whenever a modified duty release is obtained, the Client agrees to provide a modified duty position if said position can be reasonably established without a significant, adverse impact on the Client's business operations. In cases where the Client is incapable, for any reason(s), of providing a modified duty position, MatrixOneSource can act as a third-party vendor in offering modified work through its Alternative Light Duty (ALD) Program. The Client agrees to pay all applicable wages when an employee is working in any modified work position that was established by the Client directly or through the ALD program.

OSHA REPORTING

You must contact OSHA in the event of a work-related death of an employee, in patient hospitalizations, amputations, or loss of an eye by calling the OSHA central telephone number at 800-321-OSHA (6742) or in person to the area OSHA Office that is nearest to the site of the incident. Reporting should occur within the time frame established by the state where the injury occurred.

Remember: Failure to report an on-the-job injury in a timely fashion may subject your company to fines and penalties prescribed by the State Workers' Compensation Laws.

Claim Reporting Procedure

MatrixOneSource is dedicated to providing the best service possible to our clients. The Claims Department works diligently with our insurance companies to guarantee proper handling of claims and best treatment for injured employees. Workers' Compensation fraud is always a concern, and MatrixOneSource will work with our insurance carriers to properly investigate questionable claims. Any employee found to be making false reports in order to obtain benefits will be submitted under court laws.

Proper claims handling starts with you. It is imperative that all claims are reported to MatrixOneSource within 24 hours of knowledge of the claim, no matter how minor the incident. In the event of a workers' compensation injury, please follow the reporting procedures below:

CLAIM FORMS

If life or limb threatening, call 911 then contact your dedicated claims specialist and loss control representative. Do not wait to have the forms completed to report the claim.

1. Employer's Accident Investigation Report: To be completed by a representative of the company and faxed or emailed to MatrixOneSource within 24 hours of an injury or illness.
2. Witness Statement: All who witnessed the incident must complete and provide this form to their respective supervisor.
3. Employee's Report of Injury: All injuries, no matter how minor the injury, must be reported by the employee to their respective supervisor using this form.
4. Employee Refusal of Medical Treatment: To be completed by the employee if they are denying the need for medical treatment at the time the injury or illness is reported.
5. Consent for Release of Medical Information: The employee will complete the form allowing medical records to be requested for the claim to assist with any necessary investigation
6. Supervisor's Report of Injury: To be completed by the employee's supervisor if they are not the one who completed the Employer's Accident Investigation Report and if the claim would benefit from additional information.
7. Pre-Injury Job Description: To be completed by whomever oversees the employee and has the best assessment as to what their specific pre-injury job duties entail
8. Modified Duty Offer Letter: To be completed by a representative of the company when modified duty can be accommodated. Employee will sign accepting or declining the modified offer.

The Report of Injury forms must be completed immediately and sent to MatrixOneSource via email or fax. Our email address is: **WCNewClaims@matrixonesource.com** and our fax number is: 480.289.6220.

TRIAGE/TELEMED 24/7

Upon notice of injury, the injured employee can contact our triage/healthcare provider. This service comes at no additional cost and allows the injured worker to begin the process with a medical provider immediately, rather than finding a provider on their own.
This helps reduce workers' compensation medical costs, avoids unnecessary ER and urgent care visits, and improves employee productivity. Injured workers can access through a smartphone or tablet without appointments, commutes or waiting rooms.
For immediate assistance with an injury please call the toll free number listed below. If you have any questions or concerns, please feel free to call MatrixOneSource's Claims Department or Loss Control.

Claims email address:	**WCNewClaims@matrixonesource.com**
Claims fax:	480.289.6220
Claims department:	800.409.8958 extension 109008
Loss control:	asklosscontrol@vensure.com
TRIAGE/TELEMED 24/7	877.975.9295

Fraud Alert: Red Flags Regarding Workers' Compensation

If you notice any of the following "**Red Flags**," you should contact your assigned Claims Specialist or a member of the Workers' Compensation team at 800.409.8958 extension 109008.

- No specific date, time and place of incident to claim
- Late Report
- Discrepancies in witness statements and reported incident
- Incident occurs right after being hired
- Notice of incident was submitted by an attorney
- Member disgruntled, soon-to-retire, or facing imminent firing or layoff
- Member involved in seasonal work that is about to end
- Member took unexplained or excessive time off prior to claimed incident
- Member unusually familiar with the Workers' Compensation handling procedures
- Member refused to take post-accident drug test
- Incident occurred on a Monday morning
- Member is uncooperative with investigation of the incident
- Member has a short-term employment history
- Member has history of reporting un-witnessed incidents
- Reported incident occurs in an area where the Member does not work
- Member is having financial difficulties
- Refusal by Member to return to work even when modified duty is available

Safety is No Accident – It's a Way of Life!

Claims Information and Contacts

MEDICAL TREATMENT INFORMATION

When a work-related injury is reported, proper handling is important, and we want to ensure your employees receive the proper medical care. Please see the Medical Provider Network web link below. If your company is in a state requiring a medical panel and you are in need of a new one, please send an email to claims@vensure.com and in the subject line include: Request for Medical Panel, PEO, Client Name.

https://www.viiad.com/anthemcompass/BCANTHEMW001/app/home.asp

Username: N/A

Password: N/A

CLAIMS CONTACT

Your main point of contact will be your Claims Specialist listed below. I have also provided a list of key players that you may contact as well.

Jhon Cardona- WC Claims Associate

Email: jhon.cardona@vensure.com

Direct Phone Number: 520-216-4820

Juan Prieto- WC Claims Manager

Email: juan.prieto1@vensure.com

Direct Phone Number: 707-244-1309

Email:

Direct Phone Number:

CLIENT RELATIONS CONTACT

In the event the claims contact is unable to assist with any questions or concerns, please reach out to the below for support

Strategic Relations

Email: strategicrelations@vensure.com

Direct Phone Number:

Employer Accident Investigation Report

COMPLETE AND FAX OR EMAIL THIS REPORT WITHIN 24 HOURS FROM THE TIME OF ACCIDENT.

12735 Gran Bay Parkway West, Ste. 202, Jacksonville, FL 32258 | Phone: 800.409.8958 extension 109008 | Fax: 480.289.6220

The clients designated supervisor must notify MatrixOneSource (on this form) of every injury or disease suffered by an employee, arising out of and in the course of employment.

Please fill out this form by clicking on the fields and typing the appropriate information on each line.

Please complete this form as soon as possible after an incident that results in serious injury or illness occurs.
(Optional: Use to investigate a minor injury or near miss that could have resulted in a serious injury or illness.)

This is a report of a:	☐ Death	☐ Lost Time	☐ Dr. Visit Only	☐ First Aid Only	☐ Near Miss
Date of Incident:					

Employee

Last Name:	**First Name:**	**M.I.**	**SSN:**
Street Address:		**Apt:**	
City:	**State:**	**Zip:**	
Phone Number:	**Date of Birth:**	**Department:**	

History of Claims

Does Employee have any previous Work Comp Claims? ☐ No ☐ Yes

If "Yes", please provide details below such as date of claim and type of injury.

Employer

Current Employer: MatrixOneSource

Company Name:	**Date of Hire:**

Company

Was claimaint working at your company's client location?		☐ No ☐ Yes		
Date of Assignment:				
Name/Address/Location of Accident:				
Office Address:	**Suite:**	**City:**	**State:**	**Zip:**
Phone:	**Fax:**	**Nature of Business:**		

Step 1: Describe the Incident

Date of Injury:	**Hour of Injury:**	☐ AM ☐ PM
What part of employee's workday:	☐ Entering or leaving work	☐ Doing normal work activities
☐ During break	☐ Doing normal work activities	☐ During meal period
☐ Working overtime	☐ Other:	
Date Employer Notified:	**Injury Reported To:**	
Last Day Worked:	**Date Returned to Work:**	**Class Code:**
Employees Occupation (Job Title) When Injured:		**Department:**
Can a light duty position be accomodated?		☐ No ☐ Yes
Is the employee an officer, partner or relative of the employer?		☐ No ☐ Yes
Nature of Injury:	**Part of Body Injured:**	**On Company Premises?** ☐ No ☐ Yes

Employer Accident Investigation Report

Step 1: Describe the Incident			
Job Assignment:			
Was the employee paid for the day of injury?		☐ No ☐ Yes	
Time Employee Began Work: AM ☐ PM ☐			
Did the employee lose at least one full day of work after the injury?		☐ No ☐ Yes	
Hospital or Clinic Name:		**Phone:**	
City:	**State:**	**Zip:**	
If Validity of Claim is Doubted, State Reason:			
Was the injury caused by someone else?		☐ No ☐ Yes	**Name:**
Was the Employee Visibly injured?		☐ No ☐ Yes	
Was Employee noticeably confused?		☐ No ☐ Yes	
Did Employee appear intoxicated?		☐ No ☐ Yes	
Has employee recently been disciplined?		☐ No ☐ Yes	
If another person not employed by the Employer caused the Accident, give name and address:			
Name of Witness(es) if any:			

Number of attachments:	**Written witness statements:**	**Photographs:**	**Maps/drawings:**
What personal protective equipment was being used (if any)?			

Describe, step-by-step the events that led up to the injury: (Include names of any machines, parts, objects, tools, materials, and other important details)

Please include any additional comments you feel are important on a separate page.

Step 2: Why did the incident happen?

Unsafe workplace conditions: (Check all that apply)	**Unsafe acts by people:** (Check all that apply)
☐ Inadequate guard	☐ Operating without permission
☐ Unguarded hazard	☐ Operating at unsafe speed
☐ Safety device is defective	☐ Servicing equipment that has power to it
☐ Tool or equipment defective	☐ Making a safety device inoperative
☐ Workstation layout is hazardous	☐ Using defective equipment
☐ Unsafe lighting	☐ Unsafe lifting by hand
☐ Unsafe ventilation	☐ Taking an unsafe position or posture
☐ Lack of needed personal protective equipment	☐ Distraction, teasing, horseplay
☐ Lack of appropriate equipment/tools	☐ Failure to wear personal protective equipment
☐ Unsafe clothing	☐ Failure to use the available equipment/tools
☐ Other:	☐ Other:

Employer Accident Investigation Report

Step 2: Why did the incident happen?		
Did the accident involve employees or equipment from any other company?	☐ No	☐ Yes
Why did the unsafe conditions exist?		
Why did the unsafe acts occur?		
Was there a basis (such as “the job can be done more quickly” or “the product is less likely to be damaged”) that may have encouraged the unsafe conditions or acts?	☐ No	☐ Yes
Where the unsafe acts or conditions reported prior to the incident?	☐ No	☐ Yes
Have there been similar incidents or near misses prior to this one?	☐ No	☐ Yes

Step 3: How can future incidents be prevented?		
What changes:		
☐ Stop this activity	☐ Guard the hazard	☐ Train the employee(s)
☐ Train the supervisor(s)	☐ Redesign task steps	☐ Redesign work station
☐ Write a new policy/rule	☐ Enforce existing policy	☐ Routinely inspect for the hazard
☐ Personal Protective Equipment	☐ Other:	

What should be (or has been) done to carry out the suggestion(s) checked above?

Step 4: Who completed and reviewed this form? (Please Print)	
Written by:	**Title:**
Email:	**Phone Number:**
Department:	**Date:**
Reviewed by:	**Title:**
	Date:

Witness Statement Form

General Information	
Name of Injured Employee:	Employers Name:
Name of Witness:	Supervisor Name:
Position:	Street Address:
City/State/Zip:	
Phone Number:	
Location Where Incident Occurred:	
Date of Incident:	Time of Incident:
What were you (the witness) doing at the time of the incident?	
How and when did you become aware of the incident?	
What did you hear at the time of the incident?	
Who else was present?	
Describe what you saw at the time of the incident:	

I, the undersigned, make the following statement, voluntary, without threat, or promise of reward:
I have read my statement as documented above and to the best of my knowledge and belief, it is true and correct.

Signature

Date

Employee's Report of Injury

WARNING: Employees committing Workers' Compensation Fraud are subjected to severe penalties for submitting false injury claims. Every state decides how it wants to penalize workers' compensation claim fraud.

Step 1: Please complete and submit no matter how minor the injury.			
Last Name:	**First Name:**	**M.I.**	**SSN:**
Street Address:			**Apt.**
City:		**State:**	**Zip:**
Phone Number:	**Email Address:**		**Date of Birth:**
Employer:	**Job Title:**	**Department:**	
Injury Reported To:	**Position:**	**Date Reported:**	
Date of Injury:	**Last Day Worked:**	**Return to Work Date:**	
Provide name and address			
What were you doing when the injury occured?			
How did the injury occur?			
What object or substance caused the injury?			
Type of Injury:		**Part of Body:**	
What type of treatment was received?			
Who witnessed the accident?			
Was the injury caused by someone else?		☐ No	☐ Yes
Name:			
Did the accident involve employees or equipment from another company?		☐ No	☐ Yes
What actions (if any) were taken to prevent similar accidents from occuring?			
Have you had a Workers' Comp claim in the last year?		☐ No	☐ Yes
If Yes, When:			
Have you had a previous injury to this body part?		☐ No	☐ Yes
If Yes, When:			

Department:	**Job title at time of incident:**	
Are you currently going to physical therapy?	Work schedule:	
☐ No ☐ Yes	☐ Regular Full-Time	☐ Regular Part-Time
Are you taking pain medication?	☐ Seasonal	☐ Temporary
☐ No ☐ Yes	Months with this employer:	
Are you taking any other medications?	Months doing this job:	
☐ No ☐ Yes		
If yes, please list all medications:		

Employee's Report of Injury

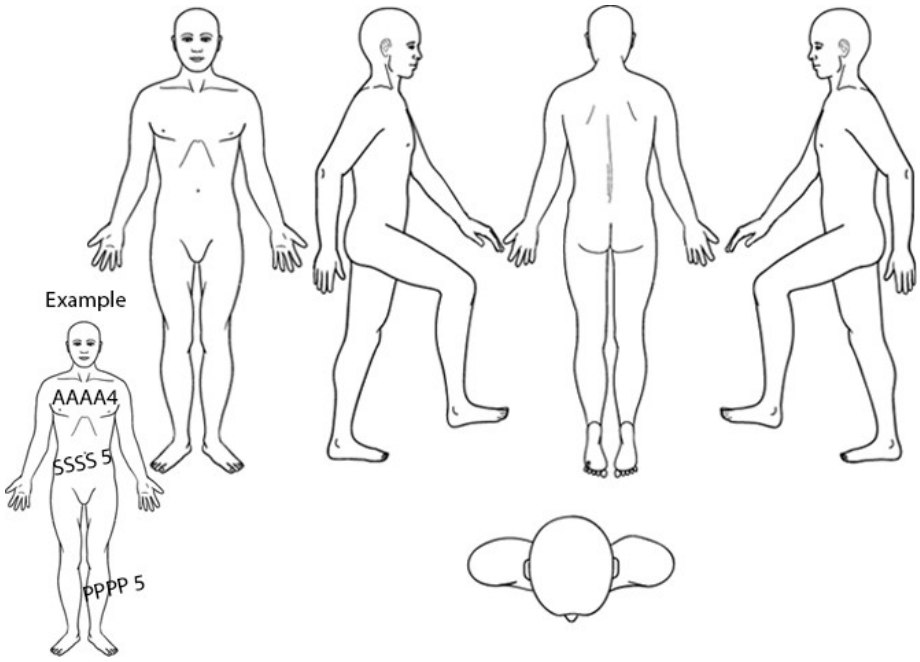
Step 2: Pain chart.

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain)

Description:	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol:	NNNN	PPPP	BBBB	AAAA	SSSS

Nature of injury: (most serious one)

☐ Abrasion, scrapes	☐ Amputation	☐ Broken Bone	☐ Bruise
☐ Burn (heat)	☐ Burn (chemical)	☐ Concussion (to the head)	☐ Crushing Injury
☐ Cut, laceration, puncture	☐ Hernia	☐ Illness	☐ Sprain, strain
☐ Damage to a body system: (e.g. nervous, respiratory, or circulatory system):			
☐ Other:			



Note: Any person who knowingly provides false, incomplete, or misleading information to any party for the purpose of obtaining workers' compensation benefits is guilty of a felony and may be subject to imprisonment, fines, and denial of insurance benefits.

Employee Name (print)

Employee Signature **Date**

Please fax completed form to 480.289.6220 or email to WCNewClaims@matrixonesource.com

Employee Refusal of Medical Treatment Form

Employee

I have been advised by my Manager/Supervisor that I may seek medical treatment for the injury that may have occurred on the job per the below listed information. I do not think medical treatment is needed at this time, but I will inform my Manager/Supervisor immediately should the need arise.

Employee's Printed Name:

Date of Injury, per Employee: **Time of Injury, per Employee:** ☐AM ☐PM

List specific body part(s) (example: right hand, index finger):

List specific injury type (example: scratch, burn, cut):

Manager/Supervisor

Comments:

Employee's Signature: _____ **Date:** _____

Manager/Supervisor Signature: _____ **Date:** _____

If you have any questions or concerns, please feel free to call MatrixOneSource's Claims Department or Loss Control.

Please fax completed form to 480.289.6220 or email to WCNewClaims@matrixonesource.com

Consent for Release of Medical Information

Employee

I hereby authorize representatives of MatrixOneSource to be permitted to obtain and review copies of all medical records related to any current or past injury or related to my medical history. Any 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 costs associated with my medical care.

Employee's Printed Name

Social Security Number

Telephone Number

Claim Number

Name of Employer

Date of Injury

Employee's Signature: _____ **Date:** _____

If you have any questions or concerns, please feel free to call MatrixOneSource's Claims Department or Loss Control.

Please fax completed form to 480.289.6220 or email to WCNewClaims@matrixonesource.com

Supervisor's Report of Injury

Please complete and submit within 24 hours no matter how minor the injury.

General Information		
Supervisor Name:	**Phone Number:**	
Email Address:		
Company:	**Injured Employee:**	
Date of Injury:	**Time of Injury:**	☐ AM ☐ PM
Injury Reported To:	**Date Reported:**	
Was the employee paid for a full days work?		☐ No ☐ Yes
Did the employee lose at least one full day of work after the injury?		☐ No ☐ Yes
Date Last Worked:	**Time:**	☐ AM ☐ PM
Has the employee returned to work?	☐ No ☐ Yes	**Date:**
Was the employee performing assigned duties?		☐ No ☐ Yes
Location Where the Injury Occured:		
What was the employee doing when injured?		
How did the injury occur?		
Object or substance that injured the employee?		
Type of Injury:	**Part of body:**	
What type of treatment was received?		
Who witnessed the accident?		
Was the injury caused by someone else? ☐ No ☐ Yes	**Name:**	
Did the accident involve employees or equipment from any other company?		☐ No ☐ Yes
What (if any) safety procedures were violated?		
Is the employee an officer, partner or relative of the employer?		☐ No ☐ Yes

Please include any additional comments you feel are important on the other side.

Supervisor Signature: _____ Date: _____

Please fax completed form to 480.289.6220 or email to WCNewClaims@matrixonesource.com

Pre-Injury Job Description

Member Information and Instructions:
The intent of the Workers' Compensation Law is to ensure that Members return to work and that the Client Company makes a good faith effort to offer work within the Member's prescribed restrictions. Providing modified duty helps ease the injured member back to work, maintains good communication and helps reduce the cost of the claim.
Supervisor Instructions:
Supervisor completes page 1. Supervisor sends the fully completed form to your assigned Claim Specialist

Client/Member Information	
Client Company:	Client ID:
Member Name:	Member # or last 4 SSN:
Member Job Title:	Department:
Supervisor:	Supervisor's Phone #:
Job Description:	

Hours Worked Per Day:				Hours Worked Per Week:			
Activity	**Yes**	**No**	**# Hours**	**Activity**	**Yes**	**No**	**# Hours**
Sitting	○	○		Crawling	○	○	
Standing	○	○		Climbing	○	○	
Walking	○	○		Reaching	○	○	
Stooping	○	○		Twist Back	○	○	
Bending	○	○		Twist Neck	○	○	
Kneeling	○	○					
Surfaces Worked on:							
Lifting Requirements:							

# Pounds	Lifting		Carrying		Push/Pull	
	Frequency	**Duration**	**Frequency**	**Duration**	**Frequency**	**Duration**
1-10						
10-25						
25-50						
Over 50						
Comments:						

Completed By:	Date:

Modified Duty Offer Letter

Date:

Employee's Name:
Employee's Address:
Employee's City, State, ZIP:

Re: Date of Injury:
Dear ____,
It is our intention to support you as you recover from your injury on the job. The attending physician __________________ has released you to return to work on ___________ (date indicated on the work status report from the physician). The physician indicated the following work restrictions:

Please report to this office as listed below, and we will make reasonable accommodations for you that will fall within the limitations of the indicated restrictions. You will be performing the following duties:

Date:
Time:
Hours per shift:
Hourly rate:
Sincerely,

____

Manager's Name

_ _

I, ____, ____ ACCEPT / ____ DECLINE this position with the understanding that a refusal of this modified-duty job offer will disqualify me from receiving lost-wage benefits under my workers' compensation claim.

Signature: ____
Date: ____________________________________

