don't just insure. BE SURE.

AlaCOMP

A Workers' Compensation Self Insurance Fund

alacompins.com 888.661.7119

P 334.215.8234 F 334.215.8479 PO Box 243007, Montgomery, AL 36124

CLAIMS REPORTING GUIDE

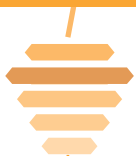

TABLE OF CONTENTS

Welcome 1

Why File a Claim and Questions about a Claim 2

Reporting a Claim and What you can do to help 3

Employer Drug Policy 4

Medical Protocol: Medical Cost Containment 5

Referral Procedures and AlaCOMP/Business Insurance Group RX Program 6

Fraud 7

rev. 4-4-18

WELCOME

Welcome to Alabama Workers' Compensation Self-Insurance Fund (AlaCOMP) and Business Insurance Group. We are grateful that you have chosen to partner with us. Our goal is to offer the best services in the industry. We will strive to help you control your losses and improve safety practices, which in turn helps your bottom line.

Our mission is to investigate all claims in a prompt and thorough manner. We manage claims with the objective of ensuring injured workers receive the best medical care to return them to their job. Services are provided with the idea that employers want their employees to receive any and all benefits due in a fair, equitable and timely manner.

AlaCOMP/Business Insurance Group's staff of claims professionals are experienced in applying our team approach to claims administration to bring about cost-effective solutions to claims. Our practices, principles and beliefs have been embraced by self-insured employers, self-insured funds and insurance companies.

Once again, thank you for giving us the opportunity to serve your insurance needs. Please call us if you have any questions.

MATT GRAHAM
Claims Manager

AlaCOMP/BUSINESS INSURANCE GROUP
P.O. Box 243007 Montgomery, AL 36124
(334) 215-8234
(888) 661-7119

claimsfirstreport@alacompins.com
Claims FAX: (334) 215-8480
Loss Control FAX: (334) 215-8479

DISCLAIMER

The Claims Reporting Guide is not intended to be a comprehensive explanation of the Alabama Workers' Compensation Law. It is designed to assist you in reporting and managing your workers' compensation claims. The Claims Reporting Guide is intended for informational purposes only and is not intended to give legal advice and is subject to change without notice.

WHY FILE A CLAIM

1. The employer must file a workers' compensation claim immediately upon notice from the employee that they have incurred an alleged on the job injury. This is an Alabama Workers' Compensation statutory requirement. Failure to report a claim could result in the denial of the claim and benefits.

2. Alabama Case Law establishes that an injured worker must give the employer notice **within 90 days** of the alleged injury. The employer must complete a legible First Report of Injury.

3. The First Report of Injury can be filed online, emailed, faxed or mailed. To obtain a First Report of Injury, visit our website alacompins.com or contact us at (888) 661-7119.

4. AlaCOMP's participation agreement in item 11 states: The employer agrees to report to the Service Organization all accidents or illness which may give rise to a worker's compensation claim immediately upon the employer's receipt of same, but no later than five (5) days following receipt of same from the employee or the employee's representative. Such notice to be given in such manner and on such forms, that may be prescribed by the Fund or the Service Organization. Employer agrees that the Fund will not be liable for defense or indemnity from any default or other judgment rendered against Employer or prejudice resulting from Employer's failure to promptly notify the Service Organization of a Claim or to provide the Service Organization with any and all legal notices, demands, summaries, legal papers and other correspondence related to Claims.

Note: Before our Claims Department can assist you with a claim, we must have the First Report of Injury (FROI).

FAQ's

1. What if you have proper notice from your employee of an on the job injury but you do not believe it is worker's compensation? **File the claim** and include on separate company letterhead why you believe it is not worker's compensation. All signed and dated claims will be thoroughly investigated. Any denials will be issued through our office and backed by a legal opinion.

2. If you have assurances from an at fault third party that they will cover the claim, do you have to file a worker's compensation claim? **YES**

3. If you receive notice after 90 days of an alleged on the job injury, do you have to file a worker's compensation claim? **YES**

4. If you receive a letter of representation from an attorney representing an employee alleging worker's compensation injury and this is your first notice, does the employer have to file a worker's compensation claim? **YES**

5. If you receive a Summons and Complaint with interrogatories regarding Count of Worker's Compensation? **Send immediately** to claimsfirstreport@alacompins.com**.** AlaCOMP/Business Insurance Group attorneys will defend and answer the interrogatories as provided for under your policy. Additional counts or charges may need to be handled separately. We will review each carefully and handle accordingly.

REPORTING A CLAIM

1. Complete Employer's First Report of Injury.
2. File the First Report of Injury:
   a. AlaCOMP portal: www.alacompins.com
   b. Email: claimsfirstreport@alacompins.com
   c. Mail: **AlaCOMP / Business Insurance Group Claims Department P.O. Box 243007 Montgomery, AL 36124**
   d. Fax: **(334) 215-8480**
3. Include any other related documentation:
   a. Downloadable forms online: treatment authorization form, wage statement, mileage record.
   b. Internal documentation: i.e. internal/supervisor's accident investigation report, medical billing/records, accident reports, etc.
4. Advise your claims adjuster of any witnesses, any possible third-party involvement or at fault, and availability of possible light/modified duty.

WHAT YOU CAN DO TO HELP

- Respond to requests promptly for information and assistance.
- Provide light/modified duty whenever possible even if available on part-time basis and/or you cannot pay the injured worker their usual wage. In such cases, we will pay temporary partial disability.
- Advise us of any injured workers' return to work.
- Unless the injured worker is represented by an attorney, stay in touch with them by calling or seeing them in person. Keep a record of such contacts and if a pattern of not being able to reach them develops, contact your claims adjuster.
- When possible, have your employee bring in any work excuses after each physician's visit. This has the advantage of keeping in touch and being able to address work availability immediately. Contact the adjuster regarding the work status and medical update.
- Advise us of any sightings or rumors of the injured workers activities that are inconsistent with the injury or disability that is being claimed.

EMPLOYER DRUG POLICY

Section 25-5-51 of the Alabama Code states that no compensation shall be allowed for an injury or death caused "by an accident due to the injured employee being intoxicated from the use of alcohol or being impaired by illegal drugs".

This company requires that you submit to drug testing in accordance with the standards adopted for drug testing by the U.S. Department of Transportation in 49 C.F.R. Part 40 immediately after you experience a work-related accident or as soon after such accident is medically possible.

Section 25-5-51 of the Alabama Code also states that no compensation shall be allowed if an employee refuses to submit to or cooperate with a blood or urine test as set out above after a work-related accident when the employee has been warned in writing that such refusal would forfeit the employee's right to recover compensation benefits.
Give a copy of this Drug Policy to each employee. Have them sign for receipt of their copy and keep it on file in their personnel folder. All employees need to know there will be no compensation if they test positive and their impairment from same is the proximate cause of the injury.

MEDICAL PROTOCOL:
MEDICAL COST CONTAINMENT

The most important right an employer has under Alabama Workers' Compensation Law is the right to choose the medical provider(s). However, most employers fail to exercise this right. We encourage all employers to implement a medical protocol.

An established medical protocol is the most cost-effective measure in claims handling.

a. It stops an employee from going to their family physician.
b. It stops an authorized physician from making a referral to a specialist who is not approved by the employer.
c. It authorizes emergency rooms to issue only enough medication to get the employee to the next business day.
d. It authorizes emergency rooms to only refer to your company's authorized primary treating physician.
e. It helps eliminate multiple emergency room visits for the sole purpose of seeking unauthorized treatment and medication.

We encourage you to establish a medical protocol program if you do not already have one. To assist you, we recommend you utilize the following:

1. Medical Protocol for Workers Compensation Injuries: This form standardizes your program between the employer, the employee and the authorized primary care physician. It is a reference guide for your HR and/or WC Coordinator. This form should be incorporated in your company's employee handbook.

2. Emergency Protocol for Workers Compensation Injuries: This form standardizes your program between the employer, the employee and the local emergency room.

3. Letter to all Employees Implementing your Medical Protocol: A one-time announcement via mass mailing or included in employee pay envelopes.

The suggested medical protocol is provided simply as a guide. Please feel free to modify it in any way to fit your company's needs. It does take effort to coordinate with your medical providers to set up and establish your medical protocol. However, once implemented, it will pay dividends in medical containment and cost effectiveness.

REFERRAL PROCEDURES

Please call the Claims Department at (888) 661-7119 regarding all referrals. Preauthorization must be obtained before treatment.

The following list of services requires authorization from an adjuster:

- All outpatient physical therapy, occupational therapy and speech therapy services as ordered by an authorized treating physician.
- All chiropractic services.
- Radiology and test services including but not limited to MRIs, CT scans, EMG/NCVs.
- Referrals to specialists by the initial treating physician (not an emergency physician) for the purpose of the specialists assuming full case management responsibilities.
- Any potential work conditioning or any functional capacity evaluation (FCE) ordered by the authorized physician that may be used for establishing an employee's ability to return to work.

****Before our Claims Department can assist with the claim, we must have the FIRST REPORT OF INJURY****

The ALACOMP/Business Insurance Group RX PROGRAM

We offer pharmacy services to injured workers through networks that can bill us directly instead of billing the patient. Our networks are chosen for convenience and cost savings benefits.

Once the authorized treating physician writes a pharmacy prescription, the injured worker may take the prescription to their pharmacy of choice. Have the pharmacy call us at (888) 661-7119 to obtain authorization from the assigned claims adjuster.

If an injured worker chooses to pay for the initial pharmacy prescription(s), they may do so. To get reimbursed for this out of pocket expense, they may submit a copy to the pharmacy receipt for reimbursement. This receipt must reflect name of medication, quantity, and prescribing physician. Send their reimbursement request to:

AlaCOMP/Business Insurance Group
ATTN: Claims Department
P.O. Box 243007
Montgomery, AL 36124

FRAUD

Alabama Criminal Code defines workers' compensation fraud as "Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining compensation as defined in Section 25-5-1(1), as amended, for himself or herself or any other person is guilty of a Class C felony."

AlaCOMP/Business Insurance Group takes fraud very seriously and is committed to the identification and investigation of claim fraud. The identification of claim fraud begins when the claim is reported and does not end until it is closed. Private investigators are used as a part of this ongoing process; however, they are very costly. And to witness the claimant acting in a way that proves fraud is often a matter of being in the right place at the right time. The employer is typically the best source of information because both they and coworkers typically live in the same community as the injured worker. Thus, we encourage employers to keep us advised of the following: known and/or rumored activities of their injured employees that are peculiar given the nature and extent of claimed injury(s); or not consistent with subjective complaints; knowledge they are working elsewhere; inability to contact them; their unwillingness to return to work; or any other activity that doesn't seem appropriate given their claim. Having said this, it is most often the case that rumors are just in fact that, rumors and without merit.

If fraud is found to exist, the matter is referred to legal counsel for review and a determination is made as to whether additional investigation is needed. We will pursue all available avenues regarding potential fraud.

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKERS'S COMPENSATION LAW

WCC Form 2

Rev. 9/2006

STATE OF ALABAMA

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Ombudsman 1-800-528-5166

CLAIM REFERENCE

1. Insured Report Number	2. Filing Office Claim Number	3. OSHA Log Case Number

EMPLOYER

4. Employer Business Name
5. Physical Address 1
6. Physical Address 2
7. City 8. State 9. Zip

ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS
10. Mailing Address 1
11. Mailing Address 2 or Telephone Number
12. City 13. State 14. Zip

15. Federal ID Number	16. U.C. Account Number	17. NAICS

INSURER / FILING OFFICE

18. Insurer Name Alacomp
19. Insurer Federal ID Number 63-1061602
20. Type Insurer ☐ Insurance Co. Ins Co #
☐ Self-Insurer SI #
☒ Group Fund GF # 19

21. Filing Office Name Business Insurance Group 21a. Service Co. #59214
22. Mailing Address 1 Po Box 243007
23. Mailing Address 2 or Telephone Number 334-215-8234
24. City Montgomery 25. State AL 26. Zip 36124
27. Filing Office Federal ID Number 33-1024937

EMPLOYEE / WAGES

28. First Name
29. Middle Name
30. Last Name
31 Last Name Suffix (ie. Jr., Sr., III)

32. Employee ID Number
33. Type Employee ID Number
SSN ☐ Passport Number ☐ Green Card ☐
Employment Visa ☐ Assigned by Jurisdiction ☐

34. Mailing Address 1
35. Mailing Address 2
36. City 37. State 38. Zip 39. Phone

40. Gender
Male ☐
Female ☐

41. Date of Birth
42.Nbr of Dependents

43. Marital Status
Unmarried (Single or Divorced or Widowed) ☐ Married ☐ Separated ☐ Unknown ☐

44. Date Hired

45. Occupation Description

46. Number of Days Worked Per Week

47. Wages $
48. Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐

49. Received Full Pay For Day of Injury? Yes ☐ No ☐
50. Did Salary Continue? Yes ☐ No ☐

INJURY / TREATMENT

51. Date of Injury	52. Time of Injury a.m. ☐ p.m. ☐ unk ☐	53. Time Employee Began Work a.m. ☐ p.m. ☐	54. Date Disability Began	55. Date of Death

PLACE OF ACCIDENT, INJURY, OR EXPOSURE

56. Site Address

57. City 58. State 59. Zip 60. County

61. Injury Occurred on Employer's Premises?
Yes ☐ No ☐

62. Date Employer Notified

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)

PROVIDE DESCRIPTION CODES to identify **Nature of Injury**, **Part of Body** that was affected, and **Cause of Injury**.

(FOR COMPLETE LIST OF CODES, GO TO HTTP:// DIR.ALABAMA.GOV/WC

64. Nature of Injury Code 65. Part of Body Code 66. Cause of Injury Code

67. Initial Treatment
No Medical Treatment ☐ First Aid By Employer ☐
Minor Clinic / Hospital ☐ Emergency Room ☐
Hospitalized > 24 Hours ☐ Major medical/Lost time ☐
Hospitalized Overnight ☐

68. Name of Treatment Facility
69. Address
70. City 71. State 72. Zip

73. Name of Physician or Other Health Care Professional

74. Has Injured Returned to Work
Yes ☐ No ☐

If so, 75. Date
76. Time a.m. ☐ p.m. ☐

OTHER

77. Date Prepared	78. Preparer's First Name	79. Last Name	80. Title	81. Preparer's Telephone Number

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKERS'S COMPENSATION LAW

NATURE OF INJURY

01. No Physical Injury
02. Amputation
03. Angina Pectoris
04. Burn
07. Concussion
10. Contusion
13. Crushing
16. Dislocation
19. Electric Shock
22. Enucleation
25. Foreign Body
28. Fracture
30. Freezing
31. Hearing Loss or Impairment
32. Heat Prostration
34. Hernia
36. Infection
37. Inflammation
40. Laceration
41. Myocardial Infarction
42. Poisoning - General
43. Puncture
46. Rupture
47. Severance
49. Sprain or Tear
52. Strain or Tear
53. Syncope
54. Asphyxiation
55. Vascular
58. Vision Loss
59. All Other Specific Injuries, NOC
60. Dust Disease, NOC
61. Asbestosis
62. Black Lung
63. Byssinosis
64. Silicosis
65. Respiratory Disorders
66. Poisoning - Chemical, (Other Than Metals)
67. Poisoning - Metal
68. Dermatitis
69. Mental Disorder
70. Radiation
71. All Other Occupational Disease Injury, NOC
72. Loss of Hearing
73. Contagious Disease
74. Cancer
75. AIDS
76. VDT - Related Diseases
77. Mental Stress
78. Carpal Tunnel Syndrome
79. Hepatitis C
80. All Other Cumulative Injury, NOC
90. Multiple Physical Injuries Only
91. Multiple Injuries Including Both Physical & Psychological

PART OF BODY

10. Multiple Head Injury
11. Skull
12. Brain
13. Ear(s)
14. Eye(s)
15. Nose
16. Teeth
17. Mouth
18. Soft Tissue
19. Facial Bones
20. Multiple Neck Injury
21. Vertebrae
22. Disc
23. Spinal Cord
24. Larynx
25. Soft Tissue
26. Trachea
30. Multiple Upper Extremities
31. Upper Arm
32. Elbow
33. Lower Arm
34. Wrist
35. Hand
36. Finger(s)
38. Shoulder(s)
39. Wrist (s) & Hand(s)
40. Multiple Trunk
41. Upper Back Area
42. Lower Back Area
43. Disc
44. Chest
45. Sacrum and Coccyx
46. Pelvis
47. Spinal Cord
48. Internal Organs
49. Heart
50. Multiple Lower Extremities
51. Hip
52. Upper Leg
53. Knee
54. Lower Leg
55. Ankle
56. Foot
57. Toes
58. Big Toes
60. Lungs
61. Abdomen Including Groin
62. Buttocks
63. Lumbar & or Sacral Vertebrae
64. Artificial Appliance
65. Insufficient Info to Properly Identify
66. No Physical Injury
90. Multiple Body Parts
91. Body Systems and Multiple Body
99. Whole Body

CAUSE OF INJURY

01. Chemicals
02. Hot Objects or Substances
03. Temperature Extremes
04. Fire or Flame
05. Steam or Hot Fluids
06. Dust, Gases, Fumes or Vapors
07. Welding Operation
08. Radiation
09. Contact With, NOC.
10. Machine or Machinery
11. Cold Objects or Substances
12. Object Handled
13. Caught In, Under or Between, NOC.
14. Abnormal Air Pressure
15. Broken Glass
16. Hand Tool, Utensil; Not Powered
17. Object Being Lifted or Handled
18. Powered Hand Tool, Appliance
19. Caught, Puncture, Scrape, NOC.
20. Collapsing Materials (Slides of Earth) Either Man Made or Natural
25. From Different Level (Elevation) Off Wall, Catwalk, Bridge, Etc.
26. From Ladder or Scaffolding
27. From Liquid or Grease Spills
28. Into Openings Shafts, Excavations, Floor Openings, Etc.
29. On Same Level
30. Slipped, Do Not Fall
31. Fall, Slip or Trip, NOC.
32. On Ice or Snow
33. On Stairs
40. Crash of Water Vehicle
41. Crash of Rail Vehicle
45. Collision or Sideswipe With Another Vehicle
46. Collision with a Fixed Object Standing Vehicle or Stationary Object
47. Crash of Airplane
48. Vehicle Upset Overturned or Jackknifed
50. Motor Vehicle, NOC.
52. Continual Noise
53. Twisting
54. Jumping
55. Holding or Carrying
56. Lifting
57. Pushing or Pulling
58. Reaching
59. Using Tool or Machinery
60. Strain or Injury By, NOC.
61. Wielding or Throwing
65. Moving Part of Machine
66. Object Being Lifted or Handled
67. Sanding, Scraping, Cleaning Operation
68. Stationary Object
69. Stepping on Sharp Object
70. Striking Against or Stepping On, NOC.
74. Fellow Worker; Patient
75. Falling or Flying Object
76. Hand Tool or Machine in Use
77. Motor Vehicle
78. Moving Parts of Machine
79. Object Being Lifted or Handled
80. Object Handled By Others
81. Struck or Injured, NOC.
82. Absorption, Ingestion or Inhalation, NOC
84. Electrical Current
85. Animal or Insect
86. Explosion or Flare Back
87. Foreign Matter (Body) in Eye(s)
88. Natural Disasters
89. Person in Act of a Crime
90. Other Than Physical Cause of Injury
91. Mold
94. Repetitive Motion Callous, Blister, Etc.
95. Rubbed or Abraded, NOC.
96. Terrorism
97. Repetitive Motion Carpel Tunnel Syndrome
98. Cumulative, NOC
99. Other - Miscellaneous, NOC

INSTRUCTIONS FOR FILING WC FIRST REPORT OF INJURY

Employers should send a completed legible form to the insurance carrier or, if self-insured, to the designated office handling their workers' compensation claims. The insurance carrier or designated office should forward this First Report on to the Workers' Compensation Division, Department of Labor, Montgomery, Alabama 36131 within fifteen (15) days from the date of injury or date of notification to the employer for all injuries for which compensation is claimed or paid. This includes deaths, permanent disabilities or temporary disabilities exceeding three (3) days).

Block 1. A number assigned by the insured to identify a specific claim
Block 2. An identifier for a specific claim within a claim administrator's claims processing system.
Block 3. Case number from log maintained for OSHA
Block 4 - Block 14. Self Explanatory
Block 15. Employer Federal ID number
Block 16. Employer Unemployment Compensation Account Number
Block 17. NAICS Industry Codes http://dir.alabama.gov/docs/forms/wc_naics.pdf
Block 18. Carrier's name
Block 19. Carrier's FEIN
Block 20. A code representing the kind of entity providing financial responsibility for the claim, exp: (I) Insurance Carrier (S) Self Insurer (G) Guarantee Fund/Group
Block 21 through Block 63. Self Explanatory
Block 64. Nature of Injury Codes http://dir.alabama.gov/docs/forms/wcio_nature_table.pdf
Block 65. Part of Body Codes http://dir.alabama.gov/docs/forms/wcio_part_table.pdf
Block 66. Cause of Injury Codes http://dir.alabama.gov/docs/forms/wcio_cause_table.pdf
Block 67 through Block 81. Self Explanatory

MILEAGE RECORD

Name:____

Address:____

____

Date of Injury: ______________________

DATE	DESTINATION AND ADDRESS	TOTAL MILEAGE

By endorsement of this form, the signee is attesting that he/she has received, understands and acknowledges the following statement:
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 insurance fraud, punishable as provided by law.

____

SIGNATURE

TREATMENT AUTHORIZATION FORM

Form to be presented to physician's office for treatment.

EMPLOYEE INFORMATION

(Valid identification is needed for all drug screens and breath alcohol tests)

Name:____________________________**Position:**_____________________________________**Date:** __________

SCREENS REQUIRED UPON TREATMENT:_____**Breath Alcohol Test** _____**Instant Drug Test**

EMPLOYER INFORMATION AND AUTHORIZATION

AUTHORIZED TREATMENT PROVIDER: ____

SUPERVISOR NAME:____________________________**OFFICE:**____________________**FAX:** __________________

CONTACT PERSONNEL:________________________________**OR** ______________________________________

Please call____________________________________at________________________________after treatment

AUTHORIZATION: This form, completed and signed by an authorized representative of ______________________________, serves as authorization to treat the above named employee and to bill for services rendered. Please submit a first report of this injury to the company as soon as possible.

Authorized Signature:______________________________________**Date:** _________________________________

BILLING INFORMATION

Submit all billing to:

AlaCOMP /Business Insurance Group
PO Box 243007
Montgomery, Alabama 36124

WAGE STATEMENT

EMPLOYEE______________________________ EMPLOYER: ________________________________

DATE OF INJURY_________________________CLAIM NO. _______________________________

Please complete this table to show the weeks worked and the **gross** wages earned by this employee for the fifty-two (52) weeks **prior to the date of injury** in accordance with Alabama Workers' Compensation Law 25-5-57(b). If this employee did not work a sufficient number of weeks to complete this table, use the wages of a fellow employee of the same class and who was engaged in the same type work for the time period stated above.

	Week Ending			Days Worked	Gross Payroll		Week Ending			Days Worked	Gross Payroll
	Mo.	Day	Year				Mo.	Day	Year		
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
15						41					
16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					
				Total	$					Total	$

Annual Total $

This report was prepared by____Date _______________

(Please complete **fringe benefit information on page two**.)

FRINGE BENEFIT INFORMATION

EMPLOYEE______________________________ EMPLOYER: ________________________________

DATE OF INJURY_________________________CLAIM NO. _______________________________

1. Please indicate if any of the following benefits are provided for this employee. If yes, list the cost (amount paid by the employer) for each benefit provided on behalf of this employee.

Health Insurance $____________

Life Insurance $____________

Disability Insurance $____________

2. Do you still provide the benefits? □ Yes or □ No

3. If no, what date did you discontinue the benefits? ____________________

Verified by____Date _________________

NOTE: Should you discontinue fringe benefits at a later date prior to resolution/closure of this employee's worker's compensation claim, notify AlaCOMP/Business Insurance Group, LLC immediately.

CHILD SUPPORT GARNISHMENT/LEVY

Have you, the employer, received an order/notice to withhold income for child support? □ Yes or □ No If yes, provide us a copy of the order.

ALABAMA DEPT OF CORRECTIONS WORK RELEASE PROGRAM

Is this employee a participant in the Work Release Program? □ Yes or □ No

If yes, provide employee's AL DEPT OF CORRECTIONS prisoner ID number. ___________________

Name (facility), address, and telephone number of the Work Release Program:______________________
____
____
____
____
____

STATE OF ALABAMA
WORKERS' COMPENSATION
INFORMATION

If you are injured on the job, or
contract an occupational disease,
notify your employer
immediately.

Your employer will advise you of
the physician to see for authorized
medical treatment.

WORKERS' COMP INSURANCE CARRIER:	AlaCOMP PO BOX 243007 Montgomery, AL 36124
TELEPHONE NUMBER:	1-888-661-7119

ASSISTANCE IS AVAILABLE UNDER THE ALABAMA WORKERS' COMPENSATION LAW INCLUDING
MEDIATION SERVICE.
FOR INFORMATION CALL: 1-
800-528-5166
Alabama Department of Labor
Workers' Compensation Division 649
Monroe Street
Montgomery, AL 36131
CODE OF ALABAMA, 1975, § 25-5-290(d), REQUIRES THAT THIS NOTICE BE POSTED
IN ONE OR MORE CONSPICUOUS PLACES IN YOUR BUSINESS.

FORM WCC#1 10/12

ABC, LLC

MEDICAL PROTOCOL FOR WORKERS COMPENSATION INJURIES

REPORT INJURY TO:

Company: ABC, LLC
Phone: (123) 456-7890
Contact Person: John Doe

TREATING PHYSICIAN:

Doctors Office
Dr. Greene
123 Apple Street
Any City, AL 12345
(444) 444-4444

EMERGENCY ROOM:

Weekends or night shift (where treating physician's office is closed)

ABC Hospital
5555 Office Way
No City, AL 67890
(098) 765-4321

- ER personnel are authorized to treat emergencies regarding the above referenced cases.
- In the event further treatment is necessary, the ER physician shall refer the employee back to the designated treating physician.
- The ER Personnel has the authority to issue enough prescription drugs to last until the next business day. Then, the emergency room physicians should instruct the employee to go back to the designated treating physician for any further prescriptions. The intent is to have all prescription management handled by one doctor.

PRESCRIPTIONS

The authorized treating physician shall prescribe generic drugs on prescriptions when available. Prescription cards are available through your adjuster.

AlaCOMP RX Program:
Once the authorized treating physician writes the prescription, the injured worker may take the prescription to the pharmacy of choice. Have the pharmacy call AlaCOMP/Business Insurance Group at (888)661-7119 to obtain authorization from the assigned claims adjuster. The injured worker can pay for the initial prescription(s) and can be reimbursed after a copy of the pharmacy receipt is submitted (to include name of medication, quantity, and prescribing physician).

EXAMPLE

(COMPANY NAME) MEMORANDUM

TO: (Employee)

FROM: Human Resource Department

DATE: (Date)

RE: Workers' Compensation Medical Protocol

Dear Employee:

The following is the established medical protocol for workers' compensation injuries that occur during the day and night shifts or on the weekends that are not life threatening or do not involve serious bodily injuries.

> **Mandatory Notice:** You must report all incidences of injury to your supervisor immediately.
>
> **Daytime workers' compensation accidents:** Report to treating physician's office.
> **Physician Name & Address**
> **Physician Phone Number**
>
> **Nighttime/Weekend workers' compensation accidents:** Report to treating physician. If their office is closed, then report to Emergency Room
> ****ER Facility Name & Address****
> ****ER Phone Number****
>
> **Emergency needs during any shift:** Any injuries that can be handled at a physician's office should be sent to the authorized treating physician. However, in the case of an emergency, or in the case of the authorized treating physician being closed, the employee should be directed to the authorized emergency room.

Failure to report to the above listed medical providers may jeopardize your workers' compensation benefits. Prior authorization must be received whenever possible.

If you have any questions please contact your HR Department.

Thanks,
Bob Smith
ABC, LLC

EXAMPLE