WHAT TO DO WHEN AN EMPLOYEE GETS HURT

First and foremost, evaluate the need for medical assistance. For emergencies, immediately call 911. For non-emergency situation, contact and coordinate care with pre-arranged medical facilities.

SERIOUS INJURIES (IN NEED OF EMERGENCY MEDICAL CARE):

- **Call 911 or transport the employee to the nearest Emergency Room**
- Provide the employee with a **"Letter of Insurance"** which has all the insurance information that the medical provider will need. This letter is available at https://allstaffpayrollservices.com/employers/
- Immediately Contact Allstaff Payroll, Inc. to report the accident

NON-SERIOUS INJURIES:

- **Send the employee to an approved, in-network, medical provider.**
- Provide the employee with a **"Letter of Insurance"** which has all the insurance information that the medical provider will need. This letter is available at https://allstaffpayrollservices.com/employers/
- In-Network Providers can be found online: https://www.goperspecta.com/VPD/broadspire/public/ProviderSearch/Main Then "Find A Doctor by Location"
- In-Network care helps ensure prompt and efficient care for employees and expedites Worker's Compensation medical bill payments.
- Immediately Contact Allstaff Payroll, Inc. to report the incident.

DRUG SCREENING:

- **ALL EMPLOYEE INJURED ON THE JOB ARE REQUIRED TO HAVE A 5-PANEL DRUG SCREENING WITHIN 48 HOURS OF THE ACCIDENT.**
- Contact Allstaff Payroll if you need assistance locating a drug testing facility for an employee that does not require immediate medical care.

PREPARE AND SUBMIT

- **First Report of Accident or Injury** – The Company Owner or Manager should complete this form. The forms are specific to the state where the business is located, and available on-line at https://allstaffpayrollservices.com/employers/. Send a copy of this report to Allstaff Payroll within 48 hours of the accident.
- **Additional Information** – Medical reports, work status information, follow-up medical appointments should be provided to Allstaff Payroll as quickly as possible.
- **Written Statement(s)** – The injured employee should provide a written statement stating what happened, where it happened, and what led up to the injury. If there were any witnesses to the accident, ask them to provide the same. Supply a copy of the statements to Allstaff Payroll. See the questionnaire on the next page.
- **Security Camera** – If the accident was on camera, send a copy of the clip to Allstaff Payroll.

AFTER THE FACT

In the days and weeks following an employee's injury, you can help support recovery by facilitating open communication. It is important to demonstrate that your workers matter to the company. By handling workplace injuries in a responsible, compassionate way you can help build and retain your most important asset – your employees.

Letter of Insurance

Provide this "Letter of Insurance" to the employee and medical provider in case of an accident or injury. It contains the insurance information that the medical provider will require to proceed with care.

During business hours the medical provider can contact Allstaff Payroll for additional information or approval if necessary.

EMPLOYEES INJURED ON THE JOB ARE REQUIRED TO HAVE A 5-PANEL DRUG SCREENING WITHIN 48 HOURS

Workers Comp Carrier:	Service America Indemnity Company
Policy Number:	RT22MWC6590052003
Third Party Administrator:	Broadspire, A Crawford Company
Email Contact:	risktransfer@choosebroadspire.com
Billing:	P.O. Box 14645 Lexington, KY 40512-4345
Telephone:	(888)-599-8726
Fax:	(678)-937-8210

After treatment, please send the First Report of Injury, injured worker's statement, any witness statements, and hospital paperwork to AllStaff Payroll by fax 850-378-5232 or email info@allstaffpayroll.com.

2101 N. 9th Ave., Pensacola, FL 32503, Telephone 850-434-6708, Fax 850-378-5232

Workers' Compensation Temporary Prescription ID Card

Broadspire
A CRAWFORD COMPANY

To the Injured Worker:

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

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx, an Express Scripts Company Customer Care at 877.804.4900.

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 a la Atención a Clientes en myMatrixx, una compañía de Express Scripts, al 877-804-4900.

Express Scripts

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 #: PD6A

Employee Date of Birth: ______/______/______

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

____

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 30-day supply or a cost of $1,500 (max $300 per medication). This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx, an Express Scripts Company Customer Care at 877.804.4900.

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

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.

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WHAT TO ASK WHEN AN EMPLOYEE GETS HURT

Employee Name, Address, and Telephone Number:

1. Location of the incident: ____________________
2. Date of incident: __________ Time of incident: __________
3. When did the injured worker report the incident/injury? ____________________
4. Accident description: ____________________
5. Who did the injured worker report the incident/injury to? ____________________
6. Describe the injuries: ____________________
7. Were there any witnesses? Yes No Name and telephone number: ____________________
8. Was there a video of the accident? Yes No
9. Where was the injured worker directed for medical treatment? ____________________
10. Job title: __________ Date of Hire: __________
11. Hourly Wage/Salary: $__________ Hr/Week/Month Average hours/week: __________
12. Is the injured worker currently working? Yes No If no, when was the last day worked?__________
13. How many scheduled workdays/hours were missed? ____________________
14. Salary being continued by the employer/client? Yes No
15. Is the client company able to accommodate light duty? Yes No Not Applicable
16. Does the injured worker have a record of disciplinary actions? Yes No
17. Is there a 3rd party at fault for this accident/injury? (Such as faulty machinery/tools, another driver, etc.) Yes No Description/Name: ____________________
18. Are you questioning the validity of the claim? Yes No
19. Are you aware of any prior worker's compensation claims by this employee? Yes No
20. Was the injured worker drug tested? Yes No If so, what were the results? __________

2101 N. 9th Ave., Pensacola, Fl 32503, Phone 850-434-6708, Fax 850-378-5232, Email info@allstaffpayroll.com

RISK TRANSFER (PROGRAM 023717) WORKERS COMPENSATION REPORTING FORM

Dial **1-888-599-8726 or**
Fax to **1-678-937-8210**
E-mail to **risktransfer@choosebroadspire.com**

(*) Indicates a Mandatory Field. **IS THIS AN EMERGENCY CLAIM? YES NO**

** REPORTED BY PERSON'S NAME/PEO NAME*					
** TITLE:*		** BUSINESS PHONE:*		EXT:	
FAX NUMBER:		E-MAIL ADDRESS:			
** DATE OF ACCIDENT: MM/DD/YYYY*		** TIME OF ACCIDENT: (HH:MM AM/PM)*			
A. POLICY HOLDER INFORMATION					
** PROGRAM NAME*	RISK TRANSFER ([PROGRAM 023717)	*INSURED NAME	Allstaff Payroll Inc.		
** ADDRESS:*	2101 N. 9th Avenue				
** CITY, STATE, ZIP:*	Pensacola, FL 32503	**COUNTY:*	Escambia		
** BUSINESS PHONE:*	850-434-6708	EXT.		FAX NUMBER:	850-378-5232
** FEDERAL ID NUMBER:*		*POLICY NUMBER			
B. CLIENT COMPANY					
**CLIENT COMPANY*					
** ADDRESS:*					
** CITY, STATE, ZIP:*		**COUNTY:*			
** BUSINESS PHONE:*		EXT.		FAX NUMBER:	
** FEDERAL ID NUMBER:*		SIC CODE:			
**LOCATION CODE:*		*NATURE OF BUSINESS			
C. LOSS LOCATION INFORMATION					
** DID ACCIDENT OCCUR ON THE CLIENT COMPANY PREMISES? (X)*	YES		NO		
** LOCATION NAME:*					
**IF NO, ENTER PHYSICAL ADDRESS:*					
** CITY, STATE, ZIP:*		**COUNTY:*			
D. INSURED CONTACT INFORMATION					
** WOULD YOU LIKE TO BE THE CONTACT PERSON?: (X)*	YES		NO		
* IF NO, ENTER CONTACT PERSON NAME:		TITLE:			
ADDRESS:					
** CITY, STATE, ZIP:*		**COUNTY:*			
CONTACT PHONE:		E-MAIL ADDRESS:			
E. INJURED WORKER INFORMATION					
**SOCIAL SECURITY NUMBER:*		** INJURED WORKER:*			
** ADDRESS:*					
** CITY, STATE, ZIP:*		COUNTY:			
RESIDENCE PHONE:		BUSINESS PHONE:		EXT:	
INJURED WORKER EMAIL ADDRESS:					
BIRTHDATE: MO/DAY/YR		**GENDER:(X)*	FEMALE	MALE	
NUMBER OF DEPENDENTS:		* MARITIAL STATUS:			
** REGULAR OCCUPATION:*		** REGULAR DEPARTMENT:*		CLASS CODE:	
DATE OF HIRE: MM/DD/YY		HIRE STATE:		STATE HIRE DATE: MM/DD/YY	
SUPERVISOR NAME:					
SUPERVISOR EMAIL ADDRESS:					
EMPLOYMENT STATUS: (Full/Part Time)					
** GROSS WAGES: (Based on Pay Type)*					
HOURS WORKED PER DAY?		DAYS WORKED PER WEEK?		HOURS PER WEEK?	

(*) indicates a Mandatory Field

F. LOSS INFORMATION							
INJURED WORKER START TIME: (HH:MM AM/PM)				* DATE EMPLOYER NOTIFIED: (MM/DD/YY)			
* QUESTIONABLE CASE?	YES		NO				
* DESCRIPTION OF ACCIDENT:							
* REMOVED BY AMBULANCE? (X)	YES		NO		UNKNOWN		
* ANY STITCHES/SURGERY REQUIRED? (X)	YES		NO				
* WAS A FATALITY INVOLVED? (X)	YES		DATE		NO		
* DESCRIBE INJURY OR ILLNESS:							
* BODY PART INJURED?:		INDICATE RIGHT/LEFT/UPPER/LOWER BODY					
* WORK PROCESS INJURED WAS DOING?							
* DIRECT CAUSE: (X)	SPECIFIC INJURY:		OCCUPATIONAL DISEASE OR CUMULATIVE INJURY :				
*SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?: (Y/N/U)		*SAFEGUARDS OR SAFETY EQUIPMENT UTILIZED?: (Y/N/U)					
*INJURED WORKER ON RESTRICTED DUTY? (X)	YES		NO		UNKNOWN		
* FULL PAY FOR DAY OF INJURY?	YES		NO		UNKNOWN		
* ANY LOST TIME? (X)	YES		NO		UNDETERMINED		
LAST DAY WORKED: MM/DD/YY			START DATE OF DISABILITY:				
DATE RETURNED TO WORK: MM/DD/YY		EXPECTED RETURN TO WORK: MM/DD/YY					
* SALARY CONTINUED DURING DISABILITY?	YES		NO		UNKNOWN		

G. MEDICAL INFORMATION						
* INITIAL TREATMENT? (X) ONLY SELECT ONE	* NO MEDICAL TREATMENT		* MINOR BY EMPLOYER			
	* MINOR HOSP/CLINIC		* EMERGENCY CARE			
	* HOSPITALIZED 24 HRS		* FUTURE MEDICAL/LOST TIME			
	* UNKNOWN					
* INJURED WORKER HOSPITALIZED OVERNIGHT AS INPATIENT?	YES		NO		UNKNOWN	

PHYSICIAN		HOSPITAL INFORMATION	
* NAME:		* NAME:	
ADDRESS:		ADDRESS:	
CITY, STATE, ZIP:		CITY, STATE, ZIP:	
BUSINESS PHONE:		BUSINESS PHONE:	

H. WITNESS INFORMATION			
* NAME:		* NAME:	
ADDRESS:		ADDRESS:	
CITY, STATE, ZIP:		CITY, STATE, ZIP:	
PHONE:		PHONE:	

I. GENERAL REMARKS/COMMENTS	
GENERAL REMARKS:	

(*) indicates a Mandatory Field