LWP Claims Solutions, Inc.
Workers' Compensation Claims Management

Claims Kit – After an Injury:
American Summit Insurance/Align General

Platinum Networks MPN

LWP CLAIMS SOLUTIONS

P.O. Box 349016, Sacramento, CA 95834

After the Injury

Table of Contents

What To Do When an Injury Occurs:

For serious injuries:

- ✓ Immediately: Dial 911 and secure medical treatment for the Injured Worker.

- ✓ Contact LWP Claims Solutions immediately when a serious injury or death occurs.

  Phone (916) 609-3600 or (800) 565-5694

- ✓ You are also required to report these injuries to the California Division of Occupational Safety and Health (**OSHA**) nearest you. See dir.ca.gov/dosh/report-accident-or-injury.html for requirements.

For all claims:

- ✓ Report claims online if you already have a link to LWP's Online reporting portal. If not,
- ✓ Complete the **Employer's Report of Occupational Injury or Illness (Form 5020).** Do not wait for a doctor's report. Submit the Employer's Report immediately by email or fax. (See "Instructions for completing the Employer's Report Injury - Form 5020")

  Email form to: **FROI@lwpclaims.com**

  Or Fax form to: (916) 720-0533

- ✓ Provide the injured worker with the **Workers' Compensation Claims Form (form DWC-1)** within one working day of your knowledge of the injury.
  - Complete the Employer's portion of the form (lower half). Retain a copy for your records.
  - Provide the Employee with the form to complete their portion (top half). If the Employee is not present, send via U.S. Mail (suggest certified)
  - Return the completed form to LWP. If Employee has not returned the form, send Employer portion to LWP.

What To Do When an Injury Occurs:

- ✓ Refer the injured worker to a medical provider.
  - ➢ For serious injuries, contact 911, and allow paramedics to transport the employee to the closest appropriate medical center.
  - ➢ For all other injuries, refer to the posted Medical panel to locate an occupational clinic or medical center.
  - ➢ Provide the employee with the following documents:
    - Health Ticket
    - Employer's Approval for Medical Attention
    - Optum First Fill Card

- ✓ Complete your accident investigation and preserve evidence as soon as possible. **Do not delay reporting the claim.**

  Complete the Supervisor's Report of Injury or Illess. This form serves to memorialize very important information about the incident

- ✓ Identify and gather witness information immediately.

  The most effective investigations are conducted immediately after an incident occurs. Witnesses are still available, facts are fresh on witnesses' minds, and evidence is still at the scene. It is particularly important to gather witness information any time an injury involves a motor vehicle, a machine, or occurs at a location other than the normal workplace.

- ✓ Preserve evidence

  It is very important to take the necessary steps to gather information and to preserve any evidence (i.e. a broken chair or machine part). It may be possible for LWP to recover our payments from another party, thus reducing your loss experience.

Please retain a copy for your records, and forward a copy of your investigation to LWP at:

FROI@lwpclaims.com

Fax: (408) 725-0395

LWP CLAIMS SOLUTIONS

Employer's Report of Occupational Injury or Illness

If you have already requested credentials to report claims via the reporting tool, please follow the instructions provided at the time you received your credentials.

If an injury occurs and you have not previously requested access to LWP's online reporting tool, please immediately complete the 5020 form and forward to LWP via email or fax.

If you have access to an online version of the 5020 form, it is "fillable" , meaning that you can type the information onto the form from your computer and print the form.

When you open the form, click in the "Firm Name" box (field), complete the information, and use the Tab key to move to the next field. Do not use the Enter key; pressing the Enter key will only page down. Each field has been limited. This means that you cannot continue to type information into a field if it doesn't fit into the space provided.

To fill in a check box, click inside the box with your mouse. Some check boxes require you to select only one answer; you cannot check both.

Once completed, you can print the form, and/or save the form by using either the "Export to PDF" or "Print to PDF" functions on your computer.

Please send the form immediately to LWP by:

- Emailing to FROI@lwpclaims.com
  Or
- Faxing to (916) 720-0533

(Note: Contact LWP at LWPwebaccess@lwpclaims.com for access to our on-line reporting tool. This tool will allow you to report claims directly into LWP's claims system.)

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:
LWP Claims Solutions, Inc., PO Box 349016, Sacramento, CA 95834
E-mail: FROI@lwpclaims.com or by Fax: 916-720-0533

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1a. Policy Number
2. MAILING ADDRESS: (Number, Street, City, Zip)
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM
9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF NJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)
20a. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.
23. Other Workers injured or ill in this event? ☐ Yes ☐ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURYIILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY
27. Name and address of physician (number, street, city, zip)
27a. Phone Number
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City,Zip)
33a. PHONE NUMBER
34. SEX ☐ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print)
Signature & Title
Date (mm/dd/yy)

Please do not use this column
CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

• Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

DWC Form 1

The Workers' Compensation Claim Form (DWC1) must be provided to the Injured Worker within 24 hours of the Employer's notification that there is a claim of injury.

The injured Worker's return of a signed form starts the "clock ticking" on all State mandated timelines, including investigation of the claim and provision of benefits.

All pages attached to the form should be provided to the Injured Worker. The form contains:

- Pages 1-3 – State Required Notifications to Injured Workers
- Page 4- two sections
    - Employee Section- to be completed by the Employee
    - Employer Section – to be completed by the Employer

Please complete the Employer Section of page 4 and provide to the Employee IMMEDIATELY upon notice that the Injured worker is claiming an injury. (Note that providing this form is NOT an admission of liability. A thorough claims investigation can then determine whether benefits are actually owed.)

How to Complete:

- Open Form
- Click in the 'Name' field and complete
- TAB to the next field (do not use 'enter"). Some fields do have limited space for text.

Once Completed:

- Print the form and/or
- Save the form using "Export to PDF' or "Print to PDF"

Please send immediately to the Injured worker and ask that it be returned to YOU as quickly as possible.

Once you receive the completed form, please send immediately to LWP by:

- Emailing to Froi@lwpclaims.com
  Or
- Faxing to (916) 720-0533

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Use the attached form to file a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If you file a claim, the claims administrator, who is responsible for handling your claim, must notify you within 14 days whether your claim is accepted or whether additional investigation is needed.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Do this right away to avoid problems with your claim. In some cases, benefits will not start until you inform your employer about your injury by filing a claim form. Describe your injury completely. Include every part of your body affected by the injury. If you mail the form to your employer, use first-class or certified mail. If you buy a return receipt, you will be able to prove that the claim form was mailed and when it was delivered. Within one working day after you file the claim form, your employer must complete the "Employer" section, give you a dated copy, keep one copy, and send one to the claims administrator.

Medical Care: Your claims administrator will pay for all reasonable and necessary medical care for your work injury or illness. Medical benefits are subject to approval and may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, medicines, equipment and travel costs. Your claims administrator will pay the costs of approved medical services directly so you should never see a bill. There are limits on chiropractic, physical therapy, and other occupational therapy visits.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness.

- If you previously designated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
- If your employer is using a medical provider network (MPN) or Health Care Organization (HCO), in most cases, you will be treated in the MPN or HCO unless you predesignated your personal physician or a medical group. An MPN is a group of health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
- If your employer is not using an MPN or HCO, in most cases, the claims administrator can choose the doctor who first treats you unless you predesignated your personal physician or a medical group.
- If your employer has not put up a poster describing your rights to workers' compensation, you may be able to be treated by your personal physician right after you are injured.

Within one working day after you file a claim form, your employer or the claims administrator must authorize up to $10,000 in treatment for your injury, consistent with the applicable treating guidelines until the claim is accepted or rejected. If the employer or claims administrator does not authorize treatment right away, talk to your supervisor, someone else in management, or the claims administrator. Ask for treatment to be authorized right now, while waiting for a decision on your claim. If the employer or claims administrator will not authorize treatment, use your own health insurance to get medical care. Your health insurer will seek reimbursement from the claims administrator. If you do not have health insurance, there are doctors, clinics or hospitals that will treat you without immediate payment. They will seek reimbursement from the claims administrator.

Switching to a Different Doctor as Your PTP:

- If you are being treated in a Medical Provider Network (MPN), you may switch to other doctors within the MPN after the first visit.
- If you are being treated in a Health Care Organization (HCO), you may switch at least one time to another doctor within the HCO. You may switch to a doctor outside the HCO 90 or 180 days after your injury is reported to your employer (depending on whether you are covered by employer-provided health insurance).
- If you are not being treated in an MPN or HCO and did not predesignate, you may switch to a new doctor one time during the first 30 days after your injury is reported to your employer. Contact the claims administrator to switch doctors. After 30 days, you may switch to a doctor of your choice if

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Utilice el formulario adjunto para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran dependiendo de la índole de su reclamo. Si usted presenta un reclamo, l administrador de reclamos, quien es responsable por el manejo de su reclamo, debe notificarle dentro de 14 días si se acepta su reclamo o si se necesita investigación adicional.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Haga esto de inmediato para evitar problemas con su reclamo. En algunos casos, los beneficios no se iniciarán hasta que usted le informe a su empleador acerca de su lesión mediante la presentación de un formulario de reclamo. Describa su lesión por completo. Incluya cada parte de su cuerpo afectada por la lesión. Si usted le envía por correo el formulario a su empleador, utilice primera clase o correo certificado. Si usted compra un acuse de recibo, usted podrá demostrar que el formulario de reclamo fue enviado por correo y cuando fue entregado. Dentro de un día laboral después de presentar el formulario de reclamo, su empleador debe completar la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos.

Atención Médica: Su administrador de reclamos pagará por toda la atención médica razonable y necesaria para su lesión o enfermedad relacionada con el trabajo. Los beneficios médicos están sujetos a la aprobación y pueden incluir tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio, las medicinas, equipos y gastos de viaje. Su administrador de reclamos pagará directamente los costos de los servicios médicos aprobados de manera que usted nunca verá una factura. Hay límites en terapia quiropráctica, física y otras visitas de terapia ocupacional.

El Médico Primario que le Atiende *(Primary Treating Physician- PTP)* es el médico con la responsabilidad total para tratar su lesión o enfermedad.

- Si usted designó previamente a su médico personal o a un grupo médico, usted podrá ver a su médico personal o grupo médico después de lesionarse.
- Si su empleador está utilizando una red de proveedores médicos (*Medical Provider Network- MPN)* o una Organización de Cuidado Médico *(Health Care Organization- HCO)*, en la mayoría de los casos, usted será tratado en la *MPN* o *HCO* a menos que usted hizo una designación previa de su médico personal o grupo médico. Una *MPN* es un grupo de proveedores de asistencia médica quien da tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una *HCO* o una *MPN*. Hable con su empleador para más información.
- Si su empleador no está utilizando una *MPN* o *HCO*, en la mayoría de los casos, el administrador de reclamos puede elegir el médico que lo atiende primero a menos de que usted hizo una designación previa de su médico personal o grupo médico.
- Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede ser tratado por su médico personal inmediatamente después de lesionarse.

Dentro de un día laboral después de que Ud. Presente un formulario de reclamo, su empleador o el administrador de reclamos debe autorizar hasta $10000 en tratamiento para su lesión, de acuerdo con las pautas de tratamiento aplicables, hasta que el reclamo sea aceptado o rechazado. Si el empleador o administrador de reclamos no autoriza el tratamiento de inmediato, hable con su supervisor, alguien más en la gerencia, o con el administrador de reclamos. Pida que el tratamiento sea autorizado ya mismo, mientras espera una decisión sobre su reclamo. Si el empleador o administrador de reclamos no autoriza el tratamiento, utilice su propio seguro médico para recibir atención médica. Su compañía de seguro médico buscará reembolso del administrador de reclamos. Si usted no tiene seguro médico, hay médicos, clínicas u hospitales que lo tratarán sin pago inmediato. Ellos buscarán reembolso del administrador de reclamos.

Cambiando a otro Médico Primario o *PTP*:

- Si usted está recibiendo tratamiento en una Red de Proveedores Médicos

your employer or the claims administrator has not created or selected an MPN.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Problems with Medical Care and Medical Reports: At some point during your claim, you might disagree with your PTP about what treatment is necessary. If this happens, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, the steps to take depend on whether you are receiving care in an MPN, HCO, or neither. For more information, see "Learn More About Workers' Compensation," below.

If the claims administrator denies treatment recommended by your PTP, you may request independent medical review (IMR) using the request form included with the claims administrator's written decision to deny treatment. The IMR process is similar to the group health IMR process, and takes approximately 40 (or fewer) days to arrive at a determination so that appropriate treatment can be given. Your attorney or your physician may assist you in the IMR process. IMR is not available to resolve disputes over matters other than the medical necessity of a particular treatment requested by your physician.

If you disagree with your PTP on matters other than treatment, such as the cause of your injury or how severe the injury is, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, notify the claims administrator in writing as soon as possible. In some cases, you risk losing the right to challenge your PTP's opinion unless you do this promptly. If you do not have an attorney, the claims administrator must send you instructions on how to be seen by a doctor called a qualified medical evaluator (QME) to help resolve the dispute. If you have an attorney, the claims administrator may try to reach agreement with your attorney on a doctor called an agreed medical evaluator (AME). If the claims administrator disagrees with your PTP on matters other than treatment, the claims administrator can require you to be seen by a QME or AME.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, you may receive temporary disability payments for a limited period. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Stay at Work or Return to Work: Being injured does not mean you must stop working. If you can continue working, you should. If not, it is important to go back to work with your current employer as soon as you are medically able. Studies show that the longer you are off work, the harder it is to get back to your original job and wages. While you are recovering, your PTP, your employer (supervisors or others in management), the claims administrator, and your attorney (if you have one) will work with you to decide how you will stay at work or return to work and what work you will do. Actively communicate with your PTP, your employer, and the claims administrator about the work you did before you were injured, your medical condition and the kinds of work you can do now, and the kinds of work that your employer could make available to you.

Payment for Permanent Disability: If a doctor says you have not recovered completely from your injury and you will always be limited in the work you can do, you may receive additional payments. The amount will depend on the type of injury, extent of impairment, your age, occupation, date of injury, and your wages before you were injured.

Supplemental Job Displacement Benefit (SJDB): If you were injured on or after 1/1/04, and your injury results in a permanent disability and your employer does not offer regular, modified, or alternative work, you may qualify for a nontransferable voucher payable for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law.

Death Benefits: If the injury or illness causes death, payments may be made to a

(Medical Provider Network- MPN), usted puede cambiar a otros médicos dentro de la MPN después de la primera visita.

- Si usted está recibiendo tratamiento en un Organización de Cuidado Médico (Healthcare Organization- HCO), es posible cambiar al menos una vez a otro médico dentro de la HCO. Usted puede cambiar a un médico fuera de la HCO 90 o 180 días después de que su lesión es reportada a su empleador (dependiendo de si usted está cubierto por un seguro médico proporcionado por su empleador).
- Si usted no está recibiendo tratamiento en una MPN o HCO y no hizo una designación previa, usted puede cambiar a un nuevo médico una vez durante los primeros 30 días después de que su lesión es reportada a su empleador. Póngase en contacto con el administrador de reclamos para cambiar de médico. Después de 30 días, puede cambiar a un médico de su elección si su empleador o el administrador de reclamos no ha creado o seleccionado una MPN.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes serán revelados. Si usted solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Problemas con la Atención Médica y los Informes Médicos: En algún momento durante su reclamo, podría estar en desacuerdo con su *PTP* sobre qué tratamiento es necesario. Si esto sucede, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, los pasos a seguir dependen de si usted está recibiendo atención en una *MPN*, *HCO* o ninguna de las dos. Para más información, consulte la sección "Aprenda Más Sobre la Compensación de Trabajadores," a continuación.

Si el administrador de reclamos niega el tratamiento recomendado por su *PTP*, puede solicitar una revisión médica independiente *(Independent Medical Review-IMR)*, utilizando el formulario de solicitud que se incluye con la decisión por escrito del administrador de reclamos negando el tratamiento. El proceso de la *IMR* es parecido al proceso de la *IMR* de un seguro médico colectivo, y tarda aproximadamente 40 (o menos) días para llegar a una determinación de manera que se pueda dar un tratamiento apropiado. Su abogado o su médico le pueden ayudar en el proceso de la *IMR*. La *IMR* no está disponible para resolver disputas sobre cuestiones aparte de la necesidad médica de un tratamiento particular solicitado por su médico.

Si no está de acuerdo con su *PTP* en cuestiones aparte del tratamiento, como la causa de su lesión o la gravedad de la lesión, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, notifique al administrador de reclamos por escrito tan pronto como sea posible. En algunos casos, usted arriesg perder el derecho a objetar a la opinión de su *PTP* a menos que hace esto de inmediato. Si usted no tiene un abogado, el administrador de reclamos debe enviarle instrucciones para ser evaluado por un médico llamado un evaluador médico calificado *(Qualified Medical Evaluator-QME)* para ayudar a resolver la disputa. Si usted tiene un abogado, el administrador de reclamos puede tratar de llegar a un acuerdo con su abogado sobre un médico llamado un evaluador médico acordado *(Agreed Medical Evaluator- AME)*. Si el administrador de reclamos no está de acuerdo con su *PTP* sobre asuntos aparte del tratamiento, el administrador de reclamos puede exigirle que sea atendido por un *QME* o *AME*.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. puede recibir pagos por incapacidad temporal por un periodo limitado. Estos pagos pueden cambiar o parar cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no puede trabajar durante más de 14 días.

Permanezca en el Trabajo o Regreso al Trabajo: Estar lesionado no significa que usted debe dejar de trabajar. Si usted puede seguir trabajando, usted debe hacerlo. Si no es así, es importante regresar a trabajar con su empleador actual tan

spouse and other relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Resolving Problems or Disputes: You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your employer or claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) or unemployment insurance (UI) benefits. Call the state Employment Development Department at (800) 480-3287 or (866) 333-4606, or go to their website at www.edd.ca.gov.

You Can Contact an Information & Assistance (I&A) Officer: State I&A officers answer questions, help injured workers, provide forms, and help resolve problems. Some I&A officers hold workshops for injured workers. To obtain important information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an I&A officer of the state Division of Workers' Compensation. You can also hear recorded information and a list of local I&A offices by calling (800) 736-7401.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their website at **www.californiaspecialist.org**.

Learn More About Workers' Compensation: For more information about the workers' compensation claims process, go to www.dwc.ca.gov. At the website, you can access a useful booklet, "Workers' Compensation in California: A Guidebook for Injured Workers." You can also contact an Information & Assistance Officer (above), or hear recorded information by calling 1-800-736-7401.

pronto como usted pueda medicamente hacerlo. Los estudios demuestran que entre más tiempo esté fuera del trabajo, más difícil es regresar a su trabajo original y a sus salarios. Mientras se está recuperando, su *PTP*, su empleador (supervisores u otras personas en la gerencia), el administrador de reclamos, y su abogado (si tiene uno) trabajarán con usted para decidir cómo va a permanecer en el trabajo o regresar al trabajo y qué trabajo hará. Comuníquese de manera activa con su *PTP*, su empleador y el administrador de reclamos sobre el trabajo que hizo antes de lesionarse, su condición médica y los tipos de trabajo que usted puede hacer ahora y los tipos de trabajo que su empleador podría poner a su disposición.

Pago por Incapacidad Permanente: Si un médico dice que no se ha recuperado completamente de su lesión y siempre será limitado en el trabajo que puede hacer, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, grado de deterioro, su edad, ocupación, fecha de la lesión y sus salarios antes de lesionarse.

Beneficio Suplementario por Desplazamiento de Trabajo *(Supplemental Job Displacement Benefit- SJDB)*: Si Ud. se lesionó en o después del 1/1/04, y su lesión resulta en una incapacidad permanente y su empleador no ofrece un trabajo regular, modificado, o alternativo, usted podría cumplir los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo un curso de reentrenamiento y/o mejorar su habilidad. Si Ud. cumple los requisios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a un cónyuge y otros parientes o a las personas que viven en el hogar que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad laboral, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (Código Laboral, sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Resolviendo problemas o disputas: Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su empleador o administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatalde Incapacidad *(State Disability Insurance- SDI)* o beneficios del desempleo *(Unemployment Insurance- UI)*. Llame al Departamento del Desarrollo del Empleo estatal al (800) 480-3287 o (866) 333-4606, o visite su página Web en www.edd.ca.gov.

Puede Contactar a un Oficial de Información y Asistencia *(Information & Assistance- I&A)*: Los Oficiales de Información y Asistencia *(I&A)* estatal contestan preguntas, ayudan a los trabajadores lesionados, proporcionan formularios y ayudan a resolver problemas. Algunos oficiales de *I&A* tienen talleres para trabajadores lesionados. Para obtener información importante sobre el proceso de la compensación de trabajadores y sus derechos y obligaciones, vaya a www.dwc.ca.gov o comuníquese con un oficial de información y asistencia de la División Estatal de Compensación de Trabajadores. También puede escuchar información grabada y una lista de las oficinas de *I&A* locales llamando al (800) 736-7401.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, o consulte su página Web en www.californiaspecialist.org.

Aprenda Más Sobre la Compensación de Trabajadores: Para obtener más información sobre el proceso de reclamos del programa de compensación de trabajadores, vaya a www.dwc.ca.gov. En la página Web, podrá acceder a un folleto útil, "Compensación del Trabajador de California: Una Guía para Trabajadores Lesionados." También puede contactar a un oficial de Información y Asistencia (arriba), o escuchar información grabada llamando al 1-800-736-7401.

PRINT CLEAR

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it "**Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
_____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
_____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. ❑ Check if you agree to receive notices about your claim by email only. ❑ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____.
You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

10. Name of employer. *Nombre del empleador.* _____
11. Address. *Dirección.* _____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.*_____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
American Summit Insurance/Align General administered by LWP Claims Solutions, Inc., P.O. Box 349016, Sacramento, CA 95834
16. Insurance Policy Number. *El número de la póliza de Seguro.*_____
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/*Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*

Rev. 1/1/2016

SUPERVISOR'S REPORT OF INJURY OR ILLNESS

Instructions: Supervisors shall use this form to report all reported work-related injuries, illnesses, or first aid events (which could have caused an injury or illness) – no matter how minor. This helps to identify and correct hazards before they cause serious injuries. This form shall be completed by Supervisors upon notice by the employee of a reported on the job injury, illness or "incident".

ALL ITEMS: MUST BE ANSWERED FULLY

WARNING: "WORKER'S COMPENSATION INSURANCE FRAUD IS A CRIME PUNISHABLE BY LAW"

EMPLOYEE INFORMATION

Type of work related incident reported: ☐ Injury ☐ Illness ☐ First Aid			
State:	Location:	Department:	Telephone:
Employee Name:	Date of Birth:	Employee Number:	
City:	Address:	State:	Zip:
Social Security:	Married: ☐ Yes ☐ No	Sex: ☐ Male ☐ Female	Age:
Job Title:		Length of Service with Company (Years):	
Hourly Wage Rate:		Job Being Performed at Time of Injury:	
Date of incident:	Time of incident:	Other Employees involved in incident: ☐ Yes ☐ No	

Release of Medical Information

I certify that the above information is true to the best of my knowledge and I authorize the release to my employer and to LWP Claims Solutions, Inc., all records relevant to my disability and my claim for disability or workers' compensation benefits, including but not limited to medical diagnosis, prognosis, treatment, and periods of hospitalization. It is understood that the Company will use the information to verify my disability and determine my eligibility of appropriate benefits. This authorization applies to physicians and other health care providers, hospitals and clinics, insurance companies and workers' compensation carriers, and organizations administering benefit programs. This authorization will remain in effect throughout my claim for workers' compensation benefits. A photocopy of this authorization will be as valid as the original.

Employee Signature: _____ Date: _____

SUPERVISOR

INCIDENT DETAILS

Date of Incident:	Time of Incident: ☐ AM ☐ PM		Date Reported:
Shift: ☐ Graveyard ☐ Days ☐ Afternoon ☐ Other:		Was Employee on Overtime: ☐ Yes ☐ No	
Incident Location (specific area):		Time Shift Commenced on employer premises? ☐ Yes ☐ No	
Witness (es) to Incident:			
Did Employee lost time due to the injury? ☐ Yes ☐ No		First Aid Given? ☐ Yes ☐ No	
Date worker left work:	Time Worker left work:	Date worker returned to work:	
Completed if Applicable (if Medical Attention is sought, complete State Form)			
Name of Medical Facility:		Doctor Name:	
Follow up appointment scheduled? ☐ Yes ☐ No		If Yes then Date and Time of next follow up:	
Was time off authorized by the physician? ☐ Yes ☐ No		If Yes then how many days?	

Treatment given:	☐ None	☐ Cast	☐ Irrigation	☐ Sutures
	☐ Brace	☐ Ace Bandage	☐ Prescription	☐ Removal of Foreign Object
	☐ Tetanus Shot		☐ Other:	

PART OF BODY INJURED – MARK ALL THAT APPLY

☐ Head	☐ Eye	☐ Left	☐ Right	☐ Hip	☐ Left	☐ Right	☐ Foot	☐ Left	☐ Right
☐ Face	☐ Elbow	☐ Left	☐ Right	☐ Thigh	☐ Left	☐ Right	☐ Ribs	☐ Left	☐ Right
☐ Nose	☐ Forearm	☐ Left	☐ Right	☐ Knee	☐ Left	☐ Right	☐ Toe	☐ Left	☐ Right
☐ Neck	☐ Hand	☐ Left	☐ Right	☐ Leg	☐ Left	☐ Right	☐ Abdomen		☐ Trunk
☐ Skin	☐ Shoulder	☐ Left	☐ Right	☐ Ankle	☐ Left	☐ Right	☐ Other:		
☐ Chest	☐ Finger (Identify):			☐ Back	☐ Upper	☐ Lower			

SUPERVISOR

NATURE OF INJURY – MARK ALL THAT APPLY

☐ Abrasion	☐ Fracture			☐ Foreign Object	☐ No Physical Injury
☐ Laceration	☐ Dislocation			☐ Inflammation	☐ Concussion
☐ Puncture	☐ Dermatitis			☐ Inhalation	☐ Electric Shock
☐ Amputation	☐ Poisoning:	☐ Chemical	☐ General	☐ Sprain	☐ Respiratory Disorders
☐ Crushing	☐ Burn:	☐ Chemical	☐ Heat	☐ Strain	☐ Mental Disorder
☐ Hernia	☐ Exposure:	☐ Cold	☐ Heat	☐ Fatality	☐ Cancer

☐ All Other *(describe):*

INVESTIGATION

Date of Investigation:		Person(s) Making Investigation:	
Employee's supervisor (print name):		Supervisor's Phone:	
Who was immediately in charge at the time of injury:			
Was employee task trained?	☐ Yes ☐ No	If Yes, explain:	
Were Safety Codes/Rules Violated?	☐ Yes ☐ No	If Yes, explain:	
Equipment Involved:	Type:	Model:	Manufacturer:

CAUSE OF INJURY – MARK ALL THAT APPLY

☐ Chemicals	☐ Building/Structures			☐ Hand Tools – Non Power	☐ Foreign Matter (Body)
☐ Vehicles	☐ Infectious Agents			☐ Hand Tools – Power	☐ Sharp Objects
☐ Conveyers	☐ Furniture/Fixtures			☐ Flame/Fire/Smoke	☐ Flying Objects
☐ Machines	☐ Falling/Flying Objects			☐ Ladders	☐ Animal/Insect
☐ Airplane	☐ Electrical	☐ High	☐ Low	☐ Stepping On, NOC.	☐ Slip/Trip/Fall
☐ Motor, NOC	☐ Object/Substance	☐ Hot	☐ Cold	☐ Noise	☐ Cumulative, NOC

☐ Other – Miscellaneous, NOC:

CAUSE OF INCIDENT – MARK AND EXPLAIN ALL THAT APPLY

☐ Horseplay	☐ Improper Material Handling	☐ Equipment Failure	☐ Excessive Speed
☐ Fatigue	☐ Wet Slippery Uneven Surface	☐ Lack of Attention	☐ Procedure Failure
☐ Poor Housekeeping		☐ Other:	

ANALYSIS

Description of Incident:

STEPS TAKEN TO PREVENT SIMILAR OCCURRENCE – MARK AND EXPLAIN ALL THAT APPLY

☐ Reinstruction of Employee Involved	☐ Formal Disciplinary Action
☐ Reminder Instruction of all Employees	☐ Installation of Guard Device
☐ Personal Protective Equipment Required	☐ Counseling of Employee

Comments:

Supervisor Signature: _____ Date: _____

REPORTE DEL SUPERVISOR SOBRE LA LESIÓN O ENFERMEDAD

Instrucciones: El supervisor utilizará este formulario para informar todos los reportes de lesiones de trabajo, o sucesos de primeros auxilios (que pudieron haber causado una lesión o enfermedad) no importando cuán leves sean. Esto ayuda a identificar y corregir riesgos antes que estos causen lesiones graves. Este formulario será completado por los supervisores al ser notificados por los empleados acerca de una lesión de trabajo, enfermedad, o "incidente".

TODA LA INFORMACIÓN DEBE CONTESTARSE COMPLETAMENTE

ADVERTENCIA: "EL FRAUDE DE SEGURO DE COMPENSACIÓN DE TRABAJADORES ES UN DELITO CASTIGADO POR LA LEY"

INFORMACIÓN DE EMPLEADO

Tipo de trabajo relacionado con el incidente reportado: ☐ Lesión ☐ Enfermedad ☐ Primeros auxilios			
Ubicación:	Estado:	Departamento:	Teléfono:
Nombre de empleado:	Fecha de nacimiento:	Número de empleado:	
Dirección:	Ciudad:	Estado:	Zip:
Seguro social:	Casado: ☐ Sí ☐ No	Sexo: ☐ M ☐ F	Edad:
Puesto de trabajo:		Tiempo de trabajo en la empresa (años):	
Salario por hora:		Trabajo Que estaba hacienda cuendo se lastimo:	
Fecha de accidente:	Hora de accidente:	Otro involucrado en accidente: ☐ Sí ☐ No	

Divulgación de información médica

Certifico que la información arriba es correcta por lo que me consta y autorizo la divulgación a mi empleador y a LWP Claims Solutions, Inc., de todos los registros relevantes a mi discapacidad y a mi reclamo de beneficios por incapacidad o compensación de trabajadores, que incluyen, pero no se limitan a, el diagnóstico médico, pronóstico, tratamiento y periodos de hospitalización. Se entiende que la Compañía utilizará la información para verificar mi discapacidad y determinar mi elegibilidad para los beneficios apropiados. Esta autorización se aplica a los médicos y otros proveedores de atención médica, hospitales y clínicas, compañías de seguros, aseguradoras de compensación de trabajadores, y organizaciones que administran programas de beneficios. Esta autorización se mantendrá abierta durante mi reclamo de beneficios de compensación de trabajadores. Una fotocopia de esta autorización será tan válida como la original.

Firma de empleado: _____ Fecha:_____

SUPERVISOR

DETALLES DEL INCIDENTE

Fecha del incidente:	Hora del incidente: ☐ AM ☐ PM		Fecha reportada:
Turno: ☐ Cementerio ☐ Días ☐ Tarde ☐ Otro:		¿Estaba en tiempo extra? ☐ Sí ☐ No	
Ubicación del incidente (área especifica):		¿Comenzó el cambio de turno en propiedad del patrón? ☐ Sí ☐ No	
Testigos del incidente:			
¿Perdió tiempo el empleado debido a la lesión? ☐ Sí ☐ No		¿Se le dio Primeros Auxilios? ☐ Sí ☐ No	
Fecha en que el trabajador dejó el trabajo:	Hora en que el trabajador se retiró:	Date worker returned to work:	
Completar si aplica (si se busca atención médica, completar Formulario de Estado)			
Nombre de hospital:		Nombre de médico:	
¿Autorizó el médico una incapacidad? ☐ Sí ☐ No		Si la respuesta es sí, fecha y hora del seguimiento:	
¿Autorizó el médico una incapacidad? ☐ Sí ☐ No		Si la respuesta es sí, ¿cuántos días?	

Tratamiento dado:	☐ Ninguno	☐ Yeso	☐ Irrigación	☐ Suturas
	☐ Ortesis	☐ Venda Ace	☐ Receta	☐ Extracción de objeto extraño
	☐ Antitetánica		☐ Otro:	

TIPO DE LESIÓN – MARQUE TODAS LAS QUE APLICAN

☐ Cabeza	☐ Ojo	☐ Izquierda	☐ Derecha	☐ Cadera	☐ Izquierda	☐ Derecha	☐ Pies	☐ Izquierda	☐ Derecha
☐ Cara	☐ Codo	☐ Izquierda	☐ Derecha	☐ Muslo	☐ Izquierda	☐ Derecha	☐ Costillas	☐ Izquierda	☐ Derecha
☐ Nariz	☐ Antebrazo	☐ Izquierda	☐ Derecha	☐ Rodilla	☐ Izquierda	☐ Derecha	☐ Dedo	☐ Izquierda	☐ Derecha
☐ Cuello	☐ Mano	☐ Izquierda	☐ Derecha	☐ Pierna	☐ Izquierda	☐ Derecha	☐ Abdomen		☐ Torso
☐ Piel	☐ Hombro	☐ Izquierda	☐ Derecha	☐ Tobillo	☐ Izquierda	☐ Derecha	☐ Otro:		
☐ Piel	☐ Dedo (cuál):			☐ Espalda	☐ Alta	☐ Baja			

SUPERVISOR

TIPO DE LESIÓN – MARQUE TODAS LAS QUE APLICAN

☐ Abrasión	☐ Fractura			☐ Objeto extraño	☐ Sin lesión física
☐ Laceración	☐ Dislocación			☐ Inflamación	☐ Conmoción
☐ Punción	☐ Dermatitis			☐ Inhalación	☐ Choque eléctrico
☐ Amputación	☐ Envenenamiento:	☐ Químico	☐ General	☐ Esguince	☐ Trastornos respiratorios
☐ Aplastamiento	☐ Quemadura:	☐ Químico	☐ Calor	☐ Esguince	☐ Trastorno mental
☐ Hernia	☐ Exposición:	☐ Frío	☐ Calor	☐ Muerte	☐ Cáncer

☐ Todas *(describir):*

INVESTIGACIÓN

Fecha de investigación:		Persona a cargo de la investigación:	
Supervisor del empleado (escribir nombre):		Teléfono del supervisor:	
¿Quién era el jefe directo al momento de la lesión?			
¿Estaba el empleado entrenado en dicha tarea?	☐ Sí ☐ No	Si la respuesta es sí, explique:	
¿Se violaron códigos / reglas de seguridad?	☐ Sí ☐ No	Si la respuesta es sí, explique:	
Equipo involucrado:	Tipo:	Modelo:	Fabricante:

CAUSA DE LESIÓN – MARQUE TODAS LAS QUE APLICAN

☐ Químicos	☐ Edificio / Estructuras			☐ Herramientas manuales no eléctricas	☐ Materia extraña (cuerpo)
☐ Vehículos	☐ Agentes infecciosos			☐ Herramientas manuales eléctricas	☐ Objetos afilados
☐ Transportadores	☐ Muebles / Accesorios			☐ Llama / Fuego / Humo	☐ Objetos voladores
☐ Máquinas	☐ Objetos cayendo / volando			☐ Escaleras	☐ Animal / Insecto
☐ Avión	☐ Eléctrico	☐ Alto	☐ Bajo	☐ Pisando, NOC	☐ Resbalón / Tropiezo / Caída
☐ Motor, NOC	☐ Objeto / Sustancia	☐ Caliente	☐ Frío	☐ Ruido	☐ NOC acumulado

☐ Otro – Varios, NOC:

CAUSA DE INCIDENTE – MARQUE TODAS LAS QUE APLICAN

☐ Bromas pesadas	☐ Manejo inadecuado de materiales	☐ Falla de equipo	☐ Exceso de velocidad
☐ Fatiga	☐ Superficie resbaladiza, mojada, y desigual	☐ Falta de atención	☐ Falla de proceso
☐ Falta de limpieza		☐ Otro:	

ANÁLISIS

Descripción de incidente:

PASOS PARA PREVENIR UN EVENTO PARECIDO – MARQUE Y EXPLIQUE TODAS LAS QUE APLICAN

☐ Instrucción de refuerzo para empleado involucrado	☐ Acción disciplinaria formal
☐ Instrucciones restantes de todos los empleados	☐ Instalación de dispositivo de protección
☐ Equipo de protección personal requerido	☐ Asesoramiento de empleado

Comentarios:

Firma de supervisor: _____ Fecha: _____

Sending the Employee to a Medical Provider

For serious injuries:

- Immediately: Dial 911 and secure medical treatment for the Injured Worker
- In these instances, the Paramedics will determine the most appropriate Medical Center. For urgent care in emergency situations, the priority is finding the best treatment. Utilizing an MPN provider is not the priority.

Finding the best provider for all other injuries:

Whenever possible, please refer the injured Employee to the facility listed on your posted Medical Panel. You can also locate an MPN provider at:

http://www.lwpclaimsplatinummpn.com/

You can access the Medical Panel function, and/or utilze the Instructions for creating a Medical Panel that is located on the http://www.lwpsignaturempn.com website.

Easing the experience for the Injured Worker

- **Provide Transportation**- It is not uncommon for Employers to drive the Injured Worker to the Industrial Clinic. The Employer must assess the individual situation, but should consider this as a show of support for the injured Employee.
- **Provide Documentation**- Supporting documentation can serve to ease the process for the Injured Worker when they reach the Provider's office. We suggest you send the Injured Worker to the Provider with the following two documents:
  - Employer's Approval for Medical Attention
  - Workers' Compensation Program (This document will assist the Physician in directing all ancillary services to the network providers,)
- **Maintain ongoing contact with the Employee**- We encourage the Employer to maintain ongoing communications with the Employee while the Employee is off work. This can serve to alleviate the concerns of the Employee and can potentially prevent litigation, as well.

Please feel free to reach out to LWP at any time.

Claims Administrator

LWP Claims Solutions, Inc. manages American Summit Insurance/Align General Captive Workers' Compensation Program claims for
Insured Name.
Please report new claims to:
Email: froi@lwpclaims.com
Fax: 916-720-0533
Mail: P.O. Box 349016, Sacramento, CA 95834

Medical Provider Network

Arch/Align General Insurance Agency is a member of the LWP Claims Solutions Platinum Medical Provider Network to locate a physician for either primary care or specialty referral you can:

- Go to www.lwpclaimsplatinummpn.com and click on the provider finder tab.
- Contact Medical Access Assistant at (855) 622-6474
- Contact LWP Examiner at (916) 609-3600

Pharmacy/ DME Transportation/ Translation

Optum is the approved Pharmacy Benefit Management Company and network

To make a referral:
Phone: (800) 547-3330

- Medical Equipment and Supplies: Option 1
- Pharmacy: Option 2
- Transportation/Language Services: Option 3

Fax: (877) 247-3330
E-mail: referralsacs@optum.com

Align Networks is the approved Physical Therapy provider.

To make a referral:
Phone: (866) 389-0211

Return to Work

This employer has a very proactive Return-to-Work program. Please provide LWP and the employer with specific actions that the employee CAN perform, so that the Employer can tailor-make a position to fit the employee's abilities.

First Aid

The employer has a First-Aid Program. If over-the-counter medications are sufficient, please direct the injured employee accordingly. Please do not provide work preclusions or prescriptions unless medically necessary to cure and relieve the effects of the injury.

Utilization Review

Fax treatment request(s) to LWP at 408-725-0395 or lwpur@genexservices.com. Treatment request that requires utilization review will be assigned to GENEX UR. Please comply with nurse and peer review requests.

Examiners do not have the ability to modify a treatment request.

Diagnostic Testing

Diagnostic testing will be arranged through
One Call Medical
All non-emergent diagnostic requests
Phone: (877) 302-4693

EMPLOYER'S APPROVAL FOR MEDICAL ATTENTION

Employee's Name: _____

Employer: _____

Date of Injury: _____

Part(s) of Body Injured: _____

Employer-Designated Treating Physician or Facility: _____

_____

Employee: Please take this form with you to medical facility indicated above.

Notice to Preferred Provider: This letter will serve as approval for the above-named employee to receive initial treatment required to cure or relieve him or her from the effects of their industrial injury. Our Third Party Administrator reserves the right to determine if further treatment is work-related and/or reasonable or necessary.

Please submit the Doctor's First Report of Injury, Form 5021, to:

LWP Claims Solutions, Inc
PO Box 349016
Sacramento, CA 95834-9016

Phone: (916) 609-3600
Fax: (916) 720-0533

Optum

PO Box 152539
Tampa, FL 33684-2539

Making it easy to get workers' compensation prescriptions filled

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured person:

If you need a prescription filled for a work-related injury, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. In most cases, the pharmacy will fill the prescription at no cost to you.

If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Please use that card for other work-related injury prescriptions.

Find a network pharmacy

Most pharmacies and all major chains are included in the network. To find a network pharmacy call **1-866-599-5426** or visit **tmesys.com**.

Questions? Need Help?

1-866-599-5426

Employer:

Immediately upon receiving notice of injury, fill in the information below and give this form to the employee.

Optum

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

LWP Claims Solutions, Inc.
CARRIER/TPA EMPLOYER

INJURED PERSON NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: **tmesys.com**.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	**004261**	or	**002538**
RxPCN	**CAL**	or	**Envoy Acct. #**
GROUP	LWPSFF		

NOTE: This First Fill card is only valid for your workers' compensation injury.

tmesys®

IMP-22-231

Optum

Hacemos más sencillo que se le abastezca las recetas de su programa de compensación por accidentes laborales

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Persona lesionada:

Si necesita que se le abastezca su receta médica para una lesión relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. En la mayoría de los casos, la farmacia abastecerá la receta sin costo para usted.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones relacionadas con su trabajo.

Cómo encontrar una farmacia de la red

La mayoría de farmacias y todas las grandes cadenas de farmacias forman parte de la red. Para ubicar una farmacia de la red, llame al **1-866-599-5426** o visite **tmesys.com**.

¿Tiene alguna pregunta? ¿Necesita ayuda?

1-866-599-5426

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información que aparece a continuación y entregue este formulario al empleado.

Optum

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

LWP Claims Solutions, Inc.
PORTADORA EMPLEADOR

NOMBRE DEL PERSONA LESIONADA

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL FECHA DE LA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite **tmesys.com**.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	**004261**	or	**002538**
RxPCN	**CAL**	or	**Envoy Acct. #**
GROUP	LWPSFF		

NOTA: Esta tarjeta First Fill solo es válida para una lesión cubierta por su programa de compensación por accidentes laborales.

tmesys®

IMP14-2013-11

LWP Claims Solutions, Inc.
Claim Service Team Directory

General Contact Information:

LWP Claims Solutions, Inc.
PO BOX 349016
Sacramento, CA 95834-9016

Main: (916) 609-3600
Toll Free Number: (866) 872-3607
General Fax: (408) 725-0395
New Loss Fax: (916) 720-0533
General Email: froi@lwpclaims.com

First Last Name
Claims Manager
Phone: (916) XXX-XXXX
Cell: (916) XXX-XXXX
Email: e-mail@lwpclaims.com

First Last Name
Claims Supervisor
Phone: (916) XXX-XXXX
Email: e-mail@lwpclaims.com

First Last Name
Sr. Claims Examiner
Phone: (916) XXX-XXXX
Email: e-mail@lwpclaims.com

First Last Name
Medical Only Examiner
Phone: (916) XXX-XXXX
Email: e-mail@lwpclaims.com