

SUA Nebraska Claim Kit



NEBRASKA CLAIM KIT INDEX

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PACKET INFORMATION & RESPONSIBILITIES NEBRASKA

The following information is designed to assist with timely and accurate reporting, as well as for education on state forms and responsibilities within the claim process. Included in this packet is the following:

- How to file a work related injury or illness claim.
- State forms as well as an explanation for completion and how to process:
 - Nebraska Workers' Compensation Court First Report of Alleged Occupational Injury or Illness – NWCC Form 1 (rev. 11/2006)
 - Nebraska Workers' Compensation Court Subsequent Report – NWCC Form 4 (rev. 06/2006)
 - Nebraska Employee's Choice or Change of Doctor Form – NWCC Form 50 (rev. 01/1997) – English/Spanish
- The responsibilities of each party involved in the claim. The information contained will assist you in understanding what each party's responsibilities include from the injured employee, client employer, PEO and insurance carrier.
- Coventry/First Script temporary prescription services ID information. This document should be provided to your injured employee at the time they report an injury and are seeking medical attention. The information contained will give pharmacists the information necessary to file the claim form with SUA and should prevent the injured employee from having to pay for the prescriptions related to the work injury. Once the claim is filed with SUA a prescription drug card will be issued to the injured worker for additional prescribed medication.
- Resources and contact information. Included in this information you will find useful internet links for state forms, Coventry Provider Network Information and key contact information for SUA, including names, department and telephone and fax numbers for staff members assigned to your account.

Thank you for choosing SUA Insurance Company

NE01 08/08



HOW TO FILE A WORK INJURY OR ILLNESS CLAIM

Workers' compensation claims can be reported in several different ways, you can:

- Complete and submit the Nebraska Workers' Compensation Court First Report of Alleged Occupational Injury or Illness – NWCC Form 1 (rev. 11/2006) via the online reporting system available at www.suainsurance.com. Email the completed form to claimsintake@suainsurance.com. **This is the preferred method of reporting an injury.**

- Complete the Nebraska Workers' Compensation Court First Report of Alleged Occupational Injury or Illness – NWCC Form 1 (rev. 11/2006) and fax to SUA at 877-782-3292.

- Complete and mail the Nebraska Workers' Compensation Court First Report of Alleged Occupational Injury or Illness – NWCC Form 1 (rev. 11/2006) to:

SUA Insurance Company
Attn: Claims Dept.
P.O. Box 06110
Chicago, IL 60606-6110

- Call the SUA Claims office at 877-782-3291. **Please refer to the Telephone Reporting Guide for assistance.**
- By contacting your broker directly and providing the appropriate first report information.
- For injuries occurring after normal business hours, please call 877-782-2112. The after hours telephone number for reporting claims provides the opportunity to report a claim 24 hours a day 7 days a week. Loss details will be gathered to determine if an emergency exists and if an immediate field contact is indicated.
- An explanation of how to complete each form is included in this packet. Also included are commonly used forms and notices and an explanation of each form's function.

NE02 08/08



TELEPHONE REPORTING GUIDE

Employer Information

Employer Name _____
Address _____
Federal Employer Identification Number (FEIN) _____
Payroll Classification Code _____

Employee Information

Name _____
Address _____
Social Security Number _____
Nationality _____
Marital Status _____
Number of Children under 18 years _____
Date of Birth _____
Occupation when injured _____
Hours worked per day _____
Average weekly wage _____

Time and Place of Injury

Location of work site where injury occurred _____
Date of Injury _____
Date Disability Began _____
When did you or the Supervisor first know about the injury _____
Name of Supervisor _____

Cause of Injury

Machine or Equipment that Caused the injury? _____
Was safety appliance provided and in use? _____
Was injury due to failure to use a safety device? _____
Describe how the injury occurred? _____

Nature of Injury

Body Part(s) injured _____
Has the employee died _____
Probable length of disability _____
Date of return to work _____
Doctor's name, address and phone number _____

SUA03 08/08



STATE FORMS NEBRASKA

- **Nebraska Workers' Compensation Court First Report of Alleged Occupational Injury or Illness – NWCC Form 1 (rev. 11/2006)** - This form is to be completed when an employee reports an injury or illness. Please complete the form with as much available information as possible.
- **Nebraska Workers' Compensation Court Subsequent Report – NWCC Form 4 (rev. 06/2006)** - This form is to be completed after the First Report of Alleged Occupational Injury or Illness.
- **Nebraska Employee's Choice or Change of Doctor Form – NWCC Form 50 (rev. 01/1997) – English/Spanish** - The employer must give this form to the injured worker as soon as possible after an injury. This form contains information about the injured workers' rights to choose a doctor to treat him/her after a work related injury.

Nebraska Workers' Compensation Court

NWCC Form 1
Revised 11/2006

First Report of Alleged Occupational Injury or Illness

Employer

Employer FEIN _____ SIC Code _____ Report Purpose _____ OSHA Log Case # _____	
Employer Name(s) _____ Address _____ City _____ State _____ Zip Code _____ Phone _____	Insured Name <i>(If different from employer name)</i> _____ Insured Address <i>(If different)</i> _____ Location _____

Insurance Carrier

Carrier FEIN _____	Administrator FEIN _____		
Name _____ Address _____ City _____ State _____ Zip Code _____ Phone _____	Claim Administrator <i>(Name, address & phone number)</i> _____		
Policy Number _____ Policy Period: From _____ To _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Self Insured <input type="checkbox"/> Check if Appropriate</td> <td style="width: 50%;">Claim Administrator Claim # _____ Jurisdiction Claim # _____</td> </tr> </table>	Self Insured <input type="checkbox"/> Check if Appropriate	Claim Administrator Claim # _____ Jurisdiction Claim # _____
Self Insured <input type="checkbox"/> Check if Appropriate	Claim Administrator Claim # _____ Jurisdiction Claim # _____		
Insurance Carrier/Self-Insured Code # _____	Insured Report # _____ Jurisdiction _____		

Employee

Name <i>(Last, First, Middle)</i> _____ Address _____ City _____ State _____ Zip Code _____ Phone _____	Full Pay for DOI Yes <input type="checkbox"/> No <input type="checkbox"/> Salary Continued Yes <input type="checkbox"/> No <input type="checkbox"/>	Number of Days Worked Per Week _____	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of Birth _____ Social Security Number _____ Date Hired _____	Marital Status Married <input type="checkbox"/> Separated <input type="checkbox"/> Unmarried <input type="checkbox"/> Unknown <input type="checkbox"/>	Wage \$ _____ Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/>	Occupational Job Title _____ Occupational Code _____ NCCI Class Code _____ Date Employee Began Work-Related Duties _____ Employment Status FT <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/>

Occurrence/Treatment

Date of Injury/Illness _____	Time Employee Began Work0 AM <input type="checkbox"/> PM <input type="checkbox"/>	Time of Occurrence AM <input type="checkbox"/> PM <input type="checkbox"/> (Cannot be determined <input type="checkbox"/>)	Last Work Date _____
Where Did Injury/Illness Occur? County _____ State _____ Zip _____		Did Injury/Illness Occur On Employer's Premises? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Date Employer Notified _____	Date Disability Began _____	Date Returned to Work _____	If Fatal, Give Date of Death _____
Type of Injury/Illness <i>(Briefly describe the nature of the injury or illness; e.g. lacerations to forearm)</i>			Nature of Injury Code _____
Part of Body Affected <i>(Indicate the part of the body affected by the injury/illness; e.g. right forearm, lowerback; and how it was affected)</i>			Part of Body Code _____
How Injury/Illness Occurred <i>(Describe activity and tools, materials, equipment the employee was using; how injury occurred)</i>			Cause of Injury Code _____
Initial Treatment: No medical treatment <input type="checkbox"/> First aid by employer <input type="checkbox"/> Minor clinic/hospital <input type="checkbox"/>	Emergency Room <input type="checkbox"/> Hospitalized overnight <input type="checkbox"/> Hospitalized > 24 hours <input type="checkbox"/>	Future major medical/lost time <input type="checkbox"/>	Name of physician or other health care provider: _____
Date Administrator Notified _____	Form Preparer's Name, Title and Phone _____		Date Prepared _____

General Instructions (Item—Definitions)

Items in bold are mandatory fields. First Report of Injury or Illness (FROI) without this information will be returned.

Employer:

- **Employer FEIN—the employer/insured's Federal Employer's Identification Number.**
- SIC Code—Standard Identification Classification code which represents the nature of the employer's business.
- Report Purpose—defines the specific purpose of the transaction. (examples: original=00; cancel=01; change=02; denial=04; correction=co).
- OSHA Log Case #—the Log Case number required for reporting to OSHA.
- **Employer Name—include all business names/doing business as (dba)**
- Address (including city, state, zip)—the address of the employer's actual location where the employee was employed at the time of the injury.
- Phone—phone number at the employer's facility.
- **Insured Name (if different from employer)—the named insured on the policy or the financially responsible self-insured employer.**
- Insured Address (if different from employer)—mailing address of the insured.
- Location—a code defined by the insured/employer which is used to identify the employer's location.

Insurance Carrier:

- **Carrier FEIN—carrier's Federal Employer's Identification Number.**
- Administrator FEIN—administrator's Federal Employer's Identification Number.
- **Name—the worker's compensation insurer, approved self insured, or intergovernmental risk management pool.**
- **Address—address, city, state, zip code of insurer.**
- Phone—phone number of insurer.
- Claim Administrator (name, address, & phone)—enter the name, address and phone number of the carrier, third party administrator, risk management pool, or self-insurer responsible for administering the claims, if different from carrier information.
- Policy #—the number assigned to the contract/policy for that employer.
- Policy Period—the effective and expiration dates of the contract/policy.
- Insurance Carrier/Self Insured Code #—for insurance carriers, the number assigned by the Nat'l Assn. of Insurance Commissioners. For self-insured employers, the code number assigned by the court.
- **Self Insured—check if appropriate.**
- **Claim Administrator Claim #—identifies a specific claim within a claim administrator's claims processing system.**
- Jurisdiction Claim #—number assigned by the court when the initial First Report is accepted.
- Insured Report #—a number used by the insured to identify a specific claim.
- Jurisdiction—the governing body or territory whose statutes apply (NE).

Employee:

- **Name—give full name as shown on payroll (avoid initials if possible).**
- **Address—address, city, state and zip code of employee.**
- Date of Birth—the date the injured worker was born.
- **Social Security Number.**
- Date Hired—the date the injured worker began his/her employment with the employer.
- Full pay for DOI (date of injury)—check one.
- Salary Continued—check one.
- Number of Days Worked Per Week—the number of the employee's regularly scheduled work days per week.
- Sex—check one.
- Number of Dependents—the number of dependents as defined by the Nebraska Workers' Compensation Act.
- Marital Status—check one.
- Wage—check one and state wage.
- Occupational Job Title—the primary occupation of the claimant at the time of the accident.
- Occupational Code—Standard Occupational Classification code used to identify the primary occupation of the employee at the time of the accident.
- NCCI Code—The identifying number for an occupational classification.
- Date Employee Began Work-Related Duties—date pertaining to employee's present occupation.
- Employment Status—check one.

Occurrence/Treatment:

- **Date of Injury/Illness—date on which the accident occurred (only one date of injury per form).**
- Time Employee Began Work—time employee began work for that date.
- Time of Occurrence—time of day the injury occurred.
- Last Work Date—the last paid work day prior to the initial date of disability.
- **Where did Injury/Illness Occur—complete county, state, and zip code.**
- Did Injury/Illness Occur On Employer's Premises—check one.
- Date Employer Notified—the date that the injury was reported to a representative of the employer.
- Date Disability Began—if not disabled answer none and skip questions.
- Date Returned to Work—if injured has returned to work, complete this question.
- If Fatal, Give Date of Death, (date employee died as a result of a work-related injury.)
- **Type of Injury/Illness—describe the nature of injury.**
- Nature of Injury Code—the code which corresponds to the nature of the injury sustained by the employee.
- Part of Body Affected—the part of the body to which the employee sustained injury.
- Part of Body Code—the code which corresponds to the Part of the body to which the employee sustained injury.
- **How Injury/Illness Occurred—a free-form description of how the accident occurred and the resulting injuries.**
- **Cause of Injury Code—the code that corresponds to the cause of injury**
- Initial Treatment—check one.
- Name of physician or other health care provider—provide name of physician or other health care provider that treated employee for injury.
- Date Administrator Notified—the date the claim administrator who is processing the claim received notice of the loss or occurrence.
- Form Preparer's Name, Title and Phone.
- Date Prepared—date form was actually completed.

Type or print neatly your response in ink.

General Instructions

Items in bold are mandatory fields. Subsequent Report of Injury (SROI) without this information will be returned.

Item—Definitions

- Employee Name—the injured worker's legally recognized name.
- **Social Security Number**—a number assigned by the Social Security Administration used to identify the employee.
- **Date of Injury**—date on which the accident occurred (*only one date of injury per form*).
- Report Effective Date—The date the payment which causes the form to be filed was made.
- **Jurisdiction**—the governing body or territory whose statutes apply (NE).
- Date Disability Began—the first day on which the employee originally lost time from work due to the occupational injury or disease or as otherwise defined by the jurisdiction.
- Pre-Existing Disability—identifies the existence of a disability that existed prior to the injury.
- Date of Representation—the date the claim administrator became aware that the claimant had secured legal representation.
- Date of Death—the date the injured worker died.
- Report Purpose—The MTC (maintenance type code) that corresponds to the reason the form is being filed.
- Released/Returned to Work (RTW) Date—the date, following the most recent disability period, on which the employee actually returned to work, or was released to return to work, as identified by the return to work qualifier.
- Released/RTW Qualifier—a code identifying the employee's return to work status, with or without physical restrictions.
- Agency Claim Number—the number assigned by the Nebraska Workers' Compensation Court to identify a specific claim.
- Number of Dependents—the number of dependents as defined by the Nebraska Workers' Compensation Act.
- Death Dependent/Payee Relationship—the relationship of the dependent(s)/payee(s) to the deceased employee; to which relationship and benefit entitlement may be determined by an adjudicator's decision for distribution of the death benefit.
- Date of Maximum Medical Improvement—the date after which further recovery from or lasting improvement to an injury or disease can no longer be anticipated based upon reasonable medical probability.
- Permanent Impairment Body Part Code—a code referencing the part(s) of body permanently impaired.
- Permanent Impairment Percentage—report the amount of part(s) of body or functional abnormality or loss which results from the injury and exists after the date of maximum medical improvements.
- Employer Name—the name of the business entity of the insured where the employee was employed at the time of the injury.
- **Employer FEIN**—the Federal Employer's Identification Number of the employer where the employee was employed at the time of the injury.
- Insured Report Number—a number used by the insured to identify a specific claim.

Wage

- Wage Period—a code indicating the time period during which the wage was earned.
- Average Weekly Wage—the average wage of the employee at the time of injury as calculated by the claims administrator or jurisdictional authority for the wage period.
- Number of Days Worked Per Week—the number of the employee's regularly scheduled work days per week.
- Salary Continued In Lieu of Comp—the employer has paid or is paying the employee's salary in lieu of compensation during an absence caused by a work-related injury.

Payments

- Payment Type—a code that identifies the payment being made.
- Payment From Date—the first start date of a benefit period for which benefits were paid.
- Payment Through Date—the last date of a benefit period for which benefits were paid.
- Payment Weeks Paid—the number of whole weeks for a specific payment code.
- Payment Days Paid—the number of days paid for a specific payment code.
- Payment Weekly Amount—the net weekly rate for the payment code being paid.
- Payment Paid to Date—the cumulative amount paid for the payment code being paid.

Benefit Adjustments

- Benefit Adjustment Type— DO NOT USE. Reserved for future use.
- Benefit Adjustment Weekly Amount— DO NOT USE. Reserved for future use.
- Benefit Adjustment Start Date— DO NOT USE. Reserved for future use.

Paid-To-Date

- Paid to Date Type—a code that identifies the type of paid to date/reduced earnings/recoveries made.
- Paid to Date Amount—the amount defined by the paid to date/reduced earnings/recoveries code.

Claim Administrator

- Insurer Name—the name of the insurer or self insured assuming the employer's financial responsibility for workers' compensation claim(s).
- **Insurer FEIN**—insurer's Federal Employer's Identification Number.
- Third Party Administrator Name—the name of the Third Party Administrator contracted to adjust the claim on behalf of the carrier or self insured.
- Third Party Administrator FEIN—the Federal Employer's Identification Number of the third party administrator's independent adjuster, contracted to adjust the claim on behalf of the insurer or self insured.
- **Claim Administrator Claim Number**—identifies a specific claim within a claim administrator's claims processing system.
- Claim Administrator Address—the address, including zip code, and telephone number of the claim administrator.
- Form Preparer's Name—the name of the person completing the form.

Claim Status

- **Claim Status**—a code representing the current status of the claim.
- Claim Type—a code representing the current benefit classification of the claim as interpreted by the jurisdiction
- Agreement to Compensate—a code used to identify the condition under which compensation benefits are being paid.
- Late Reason—a code which identifies the reasons payment/report was not made within a jurisdiction's requirements.
- Date Prepared—the date the form preparer completed the form.
- Preparer's Phone—the phone number of the person completing the form.

Type or print neatly your response in ink.

EMPLOYEE'S CHOICE OR CHANGE OF DOCTOR FORM

NOTICE TO EMPLOYER: GIVE THIS FORM TO THE INJURED WORKER AS SOON AS POSSIBLE AFTER EACH INJURY

A: RIGHTS OF THE EMPLOYEE

Under the Nebraska workers' compensation laws, you may have the right to choose a doctor to treat you for your work related injury. You may choose a doctor who has treated you or an immediate family member before this injury happened. Immediate family members are your spouse, children, parents, stepchildren and stepparents. The doctor you choose must have records to show that past treatment was provided. Your employer may ask the person who was treated to give permission so the doctor can verify past treatment.

If you want to choose your doctor, you must tell your employer the name of the doctor you choose. Do this as soon as possible after your employer gives you this notice and before getting any treatment unless it is emergency medical treatment. Once you tell your employer the name of the doctor, you may not change your choice unless your employer agrees or the Nebraska Workers' Compensation Court orders a change.

If you do not choose your doctor, your employer has the right to choose the doctor to treat you. The employer may also choose the doctor to treat you if you or your family member does not give permission so your employer can verify past treatment by the doctor you chose.

You may choose a doctor if your claim is denied. You may also choose the doctor to do major surgery or for an amputation.

You may use part B below to tell your employer the name of the doctor you choose.

B: CHOICE OF DOCTOR

I choose the following doctor to treat me for this work related injury. I certify that this doctor has treated me or an immediate family member before the work related injury.

I do not have or I do not wish to choose a doctor who has treated me or an immediate family member.

DOCTOR'S NAME

SIGNATURE OF EMPLOYEE

DOCTOR'S ADDRESS

DATE

C: USE TO CHANGE THE CHOICE MADE IN PART B, ABOVE

I wish to change my choice of doctor or I wish to choose a doctor to treat me for my work related injury. I certify the doctor named below has treated me or an immediate family member before this work related injury. I understand that I cannot make this change unless my employer agrees or unless the Nebraska Workers' Compensation Court orders a change.

DOCTOR'S NAME

SIGNATURE OF EMPLOYEE

DATE

DOCTOR'S ADDRESS

SIGNATURE OF EMPLOYER

DATE

FORMA DE SELECCION O CAMBIO DE DOCTOR POR EL EMPLEADO.

AVISO AL PATRON: DE ESTA FORMA AL TRABAJADOR LESIONADO, TAN PRONTO COMO SEA POSIBLE DESPUES DE CADA LESION

A: DERECHOS DEL EMPLEADO

Bajo la Ley de Compensación de Trabajadores en Nebraska, usted puede tener el derecho de escoger al doctor que lo trate para su lesión del trabajo. Usted puede escoger a un doctor que lo haya tratado a usted o a un miembro de su familia inmediata antes de que esta lesión haya ocurrido. Los miembros inmediatos de su familia son su esposa, sus hijos padres, hijastros y padrastros. El doctor que usted escoja debe tener archivos mostrando que tratamiento se le ha dado. Su patrón puede pedir a la persona tratada que de permiso al doctor para verificar el tratamiento pasado.

Si usted quiere escoger doctor, usted debe decir a su patrón el nombre del doctor que elija. Haga esto tan pronto como sea posible, después de que su patrón le haya dado este aviso y antes de recibir tratamiento, a menos que este tratamiento médico en emergencia. Una vez que le diga a su patrón el nombre del doctor, no podrá cambiarlo a menos que su patrón acepte o si la Corte de Compensación a Trabajadores en Nebraska ordena el cambio.

Si usted no escoje doctor, su patrón tendrá el derecho de elegir al doctor que lo trate a usted. El patrón también puede elegir el doctor que lo trate, si usted o el miembro de su familia no da permiso para que su patrón pueda verificar el tratamiento pasado por el doctor escogido por usted.

Usted puede escoger un doctor si su reclamación es negada. Usted tambien puede escoger el doctor para hacer cirugía mayor o amputación.

Usted puede usar la parte B., abajo, para decir a su patrón el nombre del doctor que ha escogido.

B: SELECCION DE DOCTOR

Yo escojo al doctor mencionado a continuación para que me trate por esta lesión del trabajo. Yo certifico que este doctor me ha tratado o ha tratado a miembros de mi familia antes de esta lesión del trabajo.

Yo no tengo o no quiero escoger a un doctor que me haya tratado a mi o a miembros de mi familia inmediata.

NOMBRE DEL DOCTOR

FIRMA DEL EMPLEADO

DOMICILIO DEL DOCTOR

FECHA

C: USE PARA CAMBIAR LA SELECCION HECHA EN LA PARTE B, ARRIBA

Yo quiero cambiar mi selección de doctor o yo quiero escoger a un doctor que me trate para mi lesión relacionada con el trabajo. Yo certifico que el doctor mencionado abajo, me ha tratado o ha tratado a miembros de mi inmediata familia antes de esta lesión en el trabajo. Yo entiendo que yo no puedo hacer este cambio a menos que mi patrón esté de acuerdo o a menos que la Corte de Compensación de Trabajadores en Nebraska ordene el cambio.

NOMBRE DEL DOCTOR

FIRMA DEL EMPLEADO

FECHA

DOMICILIO DEL DOCTOR

FIRMA DEL PATRON

FECHA



NEBRASKA FIRST REPORT OF INJURY FORMS PACKET

Nebraska Workers' Compensation Court First Report of Alleged Occupational Injury or Illness – NWCC Form 1 (rev. 11/2006)

Nebraska Workers' Compensation Court Subsequent Report – NWCC Form 4 (rev. 06/2006) –

Nebraska Employee's Choice or Change of Doctor Form – NWCC Form 50 (rev. 01/1997) – English/Spanish

Supervisor's Incident Report

Medical Authorization

Wage Statement

Attending Physicians Return to Work Recommendation Record

Job Analysis

Return to Work Log

NE04 08/08



SUPERVISOR'S INCIDENT REPORT

 Injury(work related)

 Incident

 Illness (work related)

Employee Name (First, MI, Last)			Social Security Number			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			Home Telephone Number			
Employee's Street Address						City			State		Zip Code	
Age		Birth date Mo Day Yr			Job Title			Department				
Employee's Scheduled Work Week When Injured		Start time	End time	Hrs Per Day	Hrs Per Wk	Days Per Wk		Normal Full-Time Schedule for Injured's Work	Start Time	End Time		
Injury date Mo Day Yr		Hour of Day		Last Day Worked Mo Day Yr			Last Day Worked Mo Day Yr			<input type="checkbox"/> No Lost Time <input type="checkbox"/> Date Returned to Work <input type="checkbox"/> Estimated Date of Return		

Did employee seek medical attention? Yes No

If yes, name of treating physician: _____

Name of clinic or hospital: _____

Will employee complete a drug screening? Yes No

Name of Witnesses Names (Attach statements if available)

1. _____ 2. _____

Injured employee's statement of what happened. (Identify circumstances and equipment involved)

How could this incident been prevented?

What corrective action has been taken?

Part of Body Affected							
<input type="checkbox"/> Eye	<input type="checkbox"/> Hip	<input type="checkbox"/> Head	<input type="checkbox"/> Foot	<input type="checkbox"/> Neck	<input type="checkbox"/> Wrist	<input type="checkbox"/> Back	<input type="checkbox"/> Hand
<input type="checkbox"/> Arm	<input type="checkbox"/> Toes	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Ankle	<input type="checkbox"/> Fingers	<input type="checkbox"/> Elbow	<input type="checkbox"/> Leg	<input type="checkbox"/> Other
Type of Injury							
<input type="checkbox"/> Cut/Abrasion	<input type="checkbox"/> Bruise/Contusion	<input type="checkbox"/> Foreign Object	<input type="checkbox"/> Burn	<input type="checkbox"/> Break	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Exposure	
<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> Other						

Comments _____

Supervisor Signature _____

Date _____

SUA04 08/08



WORKERS' COMPENSATION INJURY MEDICAL AUTHORIZATION

Authorization for Medical Records And Communication Release

By this form or copy thereof, I _____, hereby authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic or other related medical or medically related facility, insurance company or other organization, institution, or person, that has any records or knowledge of my mental, physical health, history, condition or well being, to supply such information to my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys.

I specifically authorize any treating physician or medical care provider to communicate orally or in writing with my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys as to my care and treatment and as to any other issues including but not limited to diagnosis, prognosis, causal connection of care and treatment to my work injury or duties and ability to work. In conjunction with this, I authorize any treating physician or medical provider to review any additional medical records provided to them.

I understand that by signing this authorization for medical records and communication release that my applicable medical provider will be releasing information subject to the HIPPA restrictions. I specifically waive any rights or protections that I may have under the HIPPA regulation and request that the medical providers release the requested information.

A photo copy of this authorization shall be valid as the original. This release shall remain valid for the length of my claim.

Name (Please Print)

Address (Street, City/Town, Zip Code)

Signature

Date Signed

SUA05 08/08



WAGE STATEMENT

Employer: _____

Employee: _____

Please provide the **52 weeks** of wages prior to the date of injury of _____

Date employee ceased to work: _____ Date Hired _____

Number of Hours employee is scheduled to work per week: _____ Claim Number _____

Is employee paid by hour, day, week or month _____ At what rate: _____

Does Employee work Overtime Yes No If yes, is Overtime mandatory Yes No

State the date and amount of any pay increases during the past 52 weeks

Date _____ Amount _____ Date _____ Amount _____

Date _____ Amount _____ Date _____ Amount _____

	Dates Incl of each Week Pd			Hrs Wkd	Regular Pay		Overtime Pay			Dates Incl of each Week Pd			Hrs Wkd	Regular Pay		Overtime Pay	
	From	To	Yr							From	To	Yr					
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								
SUBTOTAL										SUBTOTAL							
										GRAND TOTAL							

This is a correct statement of Employee's earnings as actually taken from Payroll Records

Employer's Signature _____ Title _____ Date _____

SUA06 08/08



ATTENDING PHYSICIANS RETURN TO WORK RECOMMENDATION RECORD

Claim No _____																											
Patients Name (First) _____	(Middle Initial) _____	(Last Name) _____	Date of Injury/Illness _____																								
TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK																											
Diagnosis/Condition (Brief Explanation) _____																											
I saw the and treated this patient on _____ and based on the above description of the patient's current medical problem:																											
1) <input type="checkbox"/> Recommend his/her return to work with no limitations on _____																											
2) <input type="checkbox"/> He/She may return to work on _____ capable of performing the degree of work checked below with the following restrictions:																											
<input type="checkbox"/> Sedentary Work. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as docket, ledgers and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met	1. In an 8 hour day patient may: a) Stand/Walk <input type="checkbox"/> None <input type="checkbox"/> 1-4 hours <input type="checkbox"/> 4-6 hours <input type="checkbox"/> 6-8 hours b) Sit <input type="checkbox"/> 1-3 hours <input type="checkbox"/> 3-5 hours <input type="checkbox"/> 5-8 hours c) Drive <input type="checkbox"/> 1-3 hours <input type="checkbox"/> 3-5 hours <input type="checkbox"/> 5-8 hours 2. Patient may use hand(s) for repetitive: <input type="checkbox"/> Single Grasping <input type="checkbox"/> Pushing & Pulling <input type="checkbox"/> Fine Manipulation 3. Patient may use foot/feet for repetitive movement as in operating foot controls <div style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</div> 4. Patient is able to: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Frequently</th> <th style="text-align: center;">Occasionally</th> <th style="text-align: center;">Not at All</th> </tr> </thead> <tbody> <tr> <td>Bend</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Squat</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Climb</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Twist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Reach</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>				Frequently	Occasionally	Not at All	Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/> Light Work. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls																											
<input type="checkbox"/> Light Medium Work. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.																											
<input type="checkbox"/> Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.																											
<input type="checkbox"/> Medium Heavy Work. Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds																											
<input type="checkbox"/> Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds																											
Other Instructions and/or Limitations Including Prescribed Medications: _____																											
The restrictions are in effect until _____ or until patient is reevaluated on _____																											
3) <input type="checkbox"/> He/She is total incapacitated at this time. Patient will be re-evaluated on _____.																											
Physician's Signature _____		Date _____																									

SUA07 08/08



JOB ANALYSIS

Name				Claim Number				
Address				Employer				
Date Hire		Date of Injury		Job Title		Check One <input type="checkbox"/> Skilled <input type="checkbox"/> Unskilled		
Training Required to Learn Job								
Was employee working as a Supervisor <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, number of people Supervised		Employee worked: <input type="checkbox"/> Alone <input type="checkbox"/> Small Group (3-5) <input type="checkbox"/> Large Group				
Days worked per week (Circle) M Tu W Th F Sat Sun		From		Hours worked during week To		Shift		
Work Breaks (Daily Rest Periods and Lunch)								
Morning		Lunch		Afternoon				
—		—		—		—		
Minutes		Minutes		Minutes				
Overtime Per Week Number of Hours		How Often		Was Employee Hired with Any Restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes, Specify								
Body Movements								
Sitting		%		Standing		%		
Check Appropriate Column				None	Occasionally (1/3 or Less)	Frequently (1/3 – 2/3)	Continuously (2/3 or More)	
Reaching above shoulder length								
Working with body bent over at waist								
Working in kneeling position								
Crawling								
Bending, stooping, squatting								
Repetitive foot movements as in foot controls – L/R - Both								
Climbing stairs								
Climbing ladders								
Working with arms extended at shoulder level								
Working with arms above shoulder height								
Height from floor to object to be reached and/or worked (use space for drawing, if needed)								
Object				Height				
Weights Handled		Item	Alone or Assisted	Push, Pull or Lift	Times Per Hour	Times Per Day	Times Per Week	Times Per Month
1 - 10 lbs								
15 – 20 lbs								
25 – 35 lbs								
45 – 60 lbs								
65 – 80 lbs								
85 – 100 lbs								
<input type="checkbox"/> No lifting required for this job								



Hand Coordination Activities					
Movement Required	Tool/Machine		Right	Left	Both
Major hand					
Fine manipulation					
Gross manipulation					
Simple grasping					
Power grip					
Hand twisting					
Pushing					
Pulling					
Tools Used by Worker		Weight	No. of Hands Needed to Move		
Objects Worker must Move During Day	Weight	Distance	No. of Workers' Needed to Move		
Physical Surroundings		Does Employee Walk on Uneven Ground?			
Does Employee Work <input type="checkbox"/> Inside _____% <input type="checkbox"/> Outside _____%		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Does Employee Work Around Moving Machinery?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Does Employee Drive Automotive Equipment?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, describe:					
Does the Employee Come in Contact with the Following? (indicated type)	Yes	No	Type		
Fumes					
Dust					
Mist					
Steam					
Strong Odors					
Poor Ventilation					
Air Conditioning					
Characteristics of Job that cannot be Modified by Employer for this Employee					
Comments and/or Observations					
<input type="checkbox"/> Job Site Evaluation Done			<input type="checkbox"/> Narrative		
Name(s) of Person(s) Interviewed			Title		
Person Completing Analysis			Title		Date



RETURN TO WORK LOG

Employee Name _____

Supervisor _____

Date	Hours Worked		Tasks Performed	Comment Regarding Employee's Tolerance of Modified Duty Tasks	Employee Initials	Supervisor's Initials
	In	Out				
Sunday / /						
Monday / /						
Tuesday / /						
Wednesday / /						
Thursday / /						
Friday / /						
Saturday / /						

I understand, take responsibility for and acknowledge the _____ has placed me on limitations my physician, Dr. _____ while Participating in this temporary transitional work program.

Employee Signature _____

Date _____



RETURN TO WORK LOG

The Return to Work Log is an efficient method used to monitor and document the specific tasks your employees are performing while on modified duty. It helps to eliminate potential conflicts should questions arise regarding your employees performing work in excess of their restrictions.

- A supply of forms should be centrally located and provided to each department supervisor/manager.
- Attach a copy of the employees' restrictions to the log.
- Have employees write their name on top of the log and have the Supervisor write their name.
- Remind the employees it is their responsibility to follow the restrictions.
- Remind the employees the restrictions apply to occupational and non-occupational activities.
- Employees and Supervisors review all tasks completed each day and indicate any concerns. Initial after each day in confirmation of the review of tasks and consideration of concerns.
- Have the employees sign and date the Log at each week's end.



ROLES & RESPONSIBILITIES

Employee:

If a work place accident should take place, it is your responsibility to take the following actions, injury permitting:

- You must report the work-related injury or occupational disease immediately, in writing if possible, to your employer.
- You have the right to select a physician who has maintained your medical records (or an immediate family member) when the employer notifies you of this right. If you do not have or does not choose such a physician, then the employer may select the physician. If the employer does not give you proper notice regarding the right of selection, then the restrictions on choosing and changing physicians do not apply and you have the right to select any physician.
- If it is an emergency, see any doctor as soon as you can. The rules regarding choice and change of doctor don't apply until after the emergency is over. Then, if you need more treatment, the rules apply.
- You must comply with managed care requirements for contracted medical services, including but not limited to doctors, physical therapy locations, and diagnostic testing facilities when available.

Employer:

Upon notice of a work injury or occupational disease you should take the following steps:

- Inform the insurance carrier or administrator responsible for the workers' compensation program via the agreed upon method, e.g. online reporting, facsimile, or telephonic reporting of the injury or occupational disease and either you or the insurance company should file a First Report of Alleged Occupational Injury or Illness with the court within 10 days of the date of the notice of injury (within 48 hours in the event of a death).
- To avoid delay of processing the claim it is recommended that, at a minimum, the following information be provided to the insurance carrier or administrator:
 - Employee's name
 - Address
 - Telephone number
 - Social security number
 - Brief description of the injury, accident or disease
 - Authorization Release of Medical Information
 - Notice of Claim Received
 - Witness Statements and supervisor reports, if available
- You must comply with managed care requirements for contracted medical services, including but not limited to doctors, physical therapy locations, and diagnostic testing facilities when available.



Insurance carrier:

Once SUA receives notice of a work place injury via the agreed reporting method and the claim has been properly verified and set up, SUA will take the following steps:

- Three (3) point contact for all lost time claims, contact to the employer, employee and providers.
- SUA will investigate the claim and, generally, should begin making compensation payments for lost wages (indemnity) and medical expenses within 30 days of notice of the injury. However, payment of benefits may be delayed if liability for the claim is disputed.



SUA INSURANCE COMPANY SUBROGATION PROGRAM

SUA Insurance Company (SUA) recognizes the importance of subrogation and recovery in all lines of business it writes. SUA's dedicated team of professionals works diligently to aggressively identify subrogation, second injury fund, salvage, deductible, and any other type of recovery to mitigate the overall payout of the claim.

SUA claims are handled by experienced claim professionals skilled in all aspects of workers' compensation claims handling and subrogation.

SUA maintains full-time dedicated subrogation specialists on staff overseeing all aspects of the investigation and timely notification to all parties while ensuring our lien is protected and utilized in the most advantageous means to resolve the issue.

SUA's philosophy on recovery is multifaceted and factors in all parties involved with our claims which include the insureds, Partner Agents, claim examiners, Corporate Claim Analysts, and SUA Management.

SUA believes its multifaceted approach gives each party an opportunity to recognize opportunities to help mitigate the overall payout on claims received while also recognizing possible safety hazards that can prevent future accidents from occurring.

For additional information, please contact Ed Eisman at SUA 312-258-6822.



RESOURCES

SUA Insurance – www.suainsurance.com

Coventry Workers' Comp Services – <http://coventrywcs.com>

Nebraska Workers' Compensation Court - <http://www.wcc.ne.gov/> - For General Questions
800-599-5155

Nebraska Workers' Compensation Benefits Information -
http://www.wcc.ne.gov/faq_employees.htm#general

Nebraska Insurance Fraud Division - <http://www.doi.ne.gov/fraud/ifpdindex.htm>