SUA Tennessee Claim Kit

SUA
Insurance Company

TENNESSEE CLAIM KIT INDEX

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PACKET INFORMATION & RESPONSIBILITIES
TENNESSEE

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:
  - Tennessee Workers' Compensation First Report of Work Injury – Form C-20
  - Tennessee Workers' Compensation Agreement Between Employer/Employee Choice of Physician – Form C-42 – English/Spanish
  - Tennessee Workers' Compensation Wage Statement – Form C-41
  - Tennessee Worker' Compensation Medical Waiver and Consent – Form C-31 – English/Spanish
  - Tennessee Workers' Compensation Insurance Posting Notice – Form LB-0922 (rev. 10/07) – 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.
- Workers' Compensation Poster. The law requires every employer to post and maintain in a conspicuous place or places in and about the worksite, a notice stating that the employer has secured workers' compensation insurance coverage.

Thank you for choosing SUA Insurance Company

TN01 08/08

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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 Tennessee Workers' Compensation First Report of Work Injury, Form C-20 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 Tennessee Workers' Compensation First Report of Work Injury, Form C-20 and fax to SUA at 877-782-3292.

- Complete and mail the Tennessee Workers' Compensation First Report of Work Injury, Form C-20 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.

TN02 08/08

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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

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STATE FORMS
TENNESSEE

- **Tennessee Workers' Compensation First Report of Work Injury – Form C-20** – The employer must complete this form and file same with its insurance carrier immediately after notice of injury.
- **Tennessee Workers' Compensation Agreement Between Employer/Employee Choice of Physician – Form C-42 – English/Spanish**
- **Tennessee Workers' Compensation Wage Statement – Form C-41** – This form should be completed in order to determine the correct rate of compensation to be paid to the injured employee. The average weekly wage is computed on the 52 weeks prior to date of accident.
- **Tennessee Worker' Compensation Medical Waiver and Consent – Form C-31 – English/Spanish** – This is a medical authorization form which requires the signature of the injured employee, and it permits the employer or the Division of Workers' Compensation to obtain medical information.
- **Tennessee Workers' Compensation Insurance Posting Notice – Form LB-0922 (rev. 10/07) – English/Spanish** – The law requires this notice to be conspicuously posted at the employer's place of business so all employees have access to it.

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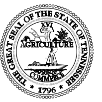

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS

CLAIMS ADM/CARRIER

- JURISDICTION CLAIM # (STATE FILE #)
- CLAIMS ADM CLAIM # (INSURER CLAIM #)
- OSHA LOG CASE #
- CLAIM TYPE CODE
  - ☐ MED ONLY
  - ☐ INDEMNITY
  - ☐ BECAME LOST TIME
  - ☐ BECAME MED ONLY
  - ☐ NOTIFY ONLY
  - ☐ TRANSFER
- NAME OF INSURANCE CARRIER
- CARRIER FEIN
- CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)
- FEIN OF CLMS ADM
- CLAIMS ADJUSTER NAME
- CLMS ADJ PHONE #
- CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2
- CITY
- STATE
- ZIP

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE TENNESSEE WORKERS' COMPENSATION LAW AND MUST BE COMPLETED AND FILED WITH YOUR INSURANCE CARRIER IMMEDIATELY AFTER NOTICE OF INJURY.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS' COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

IF YOU HAVE QUESTIONS, THE STATE NOW HAS A BENEFIT REVIEW SYSTEM WHERE A WORKERS' COMPENSATION SPECIALIST CAN PROVIDE ASSISTANCE. CALL 1-800-332-2667 (TDD).

EMPLOYER

- EMPLOYER NAME
- EMPLOYER FEIN
- SIC CODE
- PHONE NUMBER
- EMPLOYER ADDRESS LINE 1 AND LINE 2
- NATURE OF BUSINESS
- CITY
- STATE
- ZIP
- INSURED REPORT #
- EMPLOYER LOCATION

POLICY

- INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)
- POLICY NUMBER
- SELF INSURED? ☐ YES ☐ NO
- EFF DATE
- EXP DATE
- **EMPLOYMENT STATUS CODE**
  - ☐ FULL TIME/REGULAR
  - ☐ PART TIME
  - ☐ PIECE WORKER
  - ☐ SEASONAL
  - ☐ VOLUNTEER
  - ☐ APPRENTICE FULL TIME
  - ☐ APPRENTICE PART TIME

EMPLOYEE

- EMPLOYEE LAST NAME
- PHONE INCL AREA CODE
- GENDER
  - ☐ MALE
  - ☐ FEMALE
  - ☐ UNKNOWN
- FIRST
- MI
- DEPARTMENT REGULARLY WORKED
- ADDRESS LINE 1 & 2
- OCCUPATION DESCRIPTION
- CITY
- STATE
- ZIP
- MARITAL STATUS
  - ☐ UNMARRIED, SINGLE, DIVORCED
  - ☐ MARRIED
  - ☐ SEPARATED
  - ☐ UNKNOWN
- NCCI CLASS CODE
- SSN
- DATE OF BIRTH
- DATE OF HIRE

WAGE

- WAGE $
- PERIOD
  - ☐ HOURLY
  - ☐ DAILY
  - ☐ WEEKLY
  - ☐ BI-WEEKLY
  - ☐ MONTHLY
- NUMBER OF DAYS WORKED PER WEEK
- SALARY CONTINUED IN LIEU OF COMPENSATION ☐ YES ☐ NO
- FULL WAGES PAID FOR DATE OF INJURY ☐ YES ☐ NO

ACCIDENT/INJURY

- DATE OF INJURY
- TIME OF INJURY ☐ AM ☐ PM ☐ COULD NOT BE DETERMINED
- TIME EMPLOYEE BEGAN WORK ON INJURY DATE ☐ AM ☐ PM
- DATE EMPLOYER NOTIFIED OF INJURY
- BODY PART AFFECTED CODE
- NATURE OF INJURY CODE
- CAUSE OF INJURY CODE
- DATE CLAIM ADM NOTIFIED OF INJURY
- HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE INCIDENT INCLUDING WHAT THE EMPLOYEE WAS DOING JUST BEFORE, THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY HARMED THE EMPLOYEE.
- DATE LAST DAY WORKED
- DATE DISABILITY BEGAN
- RETURN TO WORK DATE (IF APPLICABLE)
- DATE OF DEATH (IF APPLICABLE)
- IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP
  - ☐ WIDOW
  - ☐ WIDOWER
  - ☐ MOTHER
  - ☐ FATHER
  - __ DAUGHTER
  - __ SON
  - __ SISTER
  - __ BROTHER
  - __ HANDICAPPED CHILD
  - TOTAL # DEPENDENTS
- DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
- ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)
  - CITY
  - STATE
  - ZIP
- COUNTY OF INJURY

TREATMENT

- PHYSICIAN NAME
- HOSPITAL OR OFF SITE TREATMENT NAME
- ADDRESS LINE 1 AND 2 (physician)
- ADDRESS LINE 1 AND 2 (hospital)
- CITY
- STATE
- ZIP
- CITY
- STATE
- ZIP
- INITIAL TREATMENT
  - ☐ NO MEDICAL TREATMENT
  - ☐ MINOR BY EMPLOYER
  - ☐ MINOR BY CLINIC/HOSPITAL
  - ☐ HOSPITALIZED > 24 HRS
  - ☐ EMERGENCY CARE
  - ☐ FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

OTHER

- DATE PREPARED
- PREPARER'S NAME & TITLE
- PREPARER'S COMPANY NAME
- PHONE NUMBER

FORM C-42

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Division of Workers' Compensation
220 French Landing Dr.
Nashville, Tennessee 37243-1002

AGREEMENT BETWEEN EMPLOYER/EMPLOYEE CHOICE OF PHYSICIAN

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

In compliance with The Tennessee Workers' Compensation Law, T.C.A. Section 50-6-204

The injured employee shall accept the medical benefits afforded hereunder; provided, the employer shall designate a group of three (3) or more reputable physicians or surgeons not associated together in practice, if available in that community, from which the injured employee shall have the privilege of selecting the operating surgeon and the attending physician. If the injury is a back injury, the statutory panel must be expanded to 4, one of whom must be a chiropractor with treatment limited to 12 chiropractic visits. Further, if the injury or illness requires the treatment of a physician or surgeon who practices orthopedic or neuroscience medicine, the employer **may** appoint a panel practicing orthopedic or neuroscience medicine consisting of 5 physicians, with no more than 4 physicians affiliated in practice. If the employer provides this panel, the injured employee shall be entitled to have a second opinion on the issue of surgery, impairment, and a diagnosis from that same panel.

1. ______________________________ ______________________________
PHYSICIAN'S NAME PHONE
____
OFFICE ADDRESS CITY STATE ZIP

2. ______________________________ ______________________________
PHYSICIAN'S NAME PHONE
____
OFFICE ADDRESS CITY STATE ZIP

3. ______________________________ ______________________________
PHYSICIAN'S NAME PHONE
____
OFFICE ADDRESS CITY STATE ZIP

4. ______________________________ ______________________________
PHYSICIAN'S or CHIROPRACTOR'S NAME PHONE
____
OFFICE ADDRESS CITY STATE ZIP

5. ______________________________ ______________________________
PHYSICIAN'S NAME PHONE
____
OFFICE ADDRESS CITY STATE ZIP

(d)(1) "The injured employee must submit to examination by the employer's physician at all reasonable times if requested to do so by the employer, but the employee shall have the right to have the employee's own physician present at such examination, in which case the employee shall be liable to such physician for such physician's services."

(7) "If the injured employee refuses to comply with any reasonable request for examination or to accept the medical or specialized medical services which the employer is required to furnish under the provisions of this law, such injured employee's right to compensation shall be suspended and no compensation shall be due and payable while such injured employee continues such refusal."

According to the provisions of this agreement, I hereby have selected the following physician from the list provided to me by my employer.

Physician chosen: ______________________ Date of injury: ______________________

Date of selection: ______________________ Date of appointment: ______________________

____
Employer's Name
____
Street Address
____
City State Zip
____
Phone
____
Employer's Signature

____
Employee's Name
____
Street Address
____
City State Zip
____
Phone
____
Employee's Signature
____
Employee's SSN
____
State File Number

FORMA C-42

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Division of Workers' Compensation
220 French Landing Drive
Nashville, Tennessee 37243-1002
Website: www.state.tn.us/labor-wfd/wcomp.html
Telephone: 1-800-332-2667

La ELECCION del EMPLEADO DE MEDICO

Es un crimen dar deliberadamente información falsa, incompleta o engañosa a cualquiera de las partes involucradas en una transacción de compensación de un trabajador con el fin de cometer fraude. Las penas incluyen encarcelamiento, multas y negación de las prestaciones del seguro.

Indique el Número del Archivo: ______________________ La fecha de la Lesión: ______________________

Empleado: ______________________________________ SSN: ____________________________________

Dirección: ________________________________ Ciudad: _________________ Estado: ______ Código postal:

Empleador: ______________________________________ FEIN: ____________________________________

Dirección: ________________________________ Ciudad: _________________ Estado: ______ Código postal:

El SELECCIÓN DE MEDICOS

Un selección de tres médicos se requiere. Si la lesión es una lesión de espalda que el selección debe ser ensanchado a cuatro, uno de quien debe ser un quiropráctico. Las visitas del quiropráctico se pueden autorizar hasta doce (12) visitas por la lesión de espalda. Más de doce (12) visitas a tal médico de la quiropráctica deben ser aprobadas específicamente por el portador de empleador o seguro. El empleado herido debe escoger a un médico (o el quiropráctico) del selección.

Los médicos Denominan: ____________________________________ Teléfono: ________________________

Dirección: ________________________________ Ciudad: _________________ Estado: ______ Código postal:

Es Médico un Especialista? ☐ Sí ☐ No Si sí, da la especialidad: Ortopédico, el Neurocirujano, Chiropratic, etc. ___

Los médicos Denominan: ____________________________________ Teléfono: ________________________

Dirección: ________________________________ Ciudad: _________________ Estado: ______ Código postal:

Es Médico un Especialista? ☐ Sí ☐ No Si sí, da la especialidad: Ortopédico, el Neurocirujano, Chiropratic, etc.____

Los médicos Denominan: ____________________________________ Teléfono: ________________________

Dirección: ________________________________ Ciudad: _________________ Estado: ______ Código postal:

Es Médico un Especialista? ☐ Sí ☐ No Si sí, da la especialidad: Ortopédico, el Neurocirujano, Chiropratic, etc. ___

Los médicos Denominan: ____________________________________ Teléfono: ________________________

Dirección: ________________________________ Ciudad: _________________ Estado: ______ Código postal:

Es Médico un Especialista? ☐ Sí ☐ No Si sí, da la especialidad: Ortopédico, el Neurocirujano, Chiropratic, etc.____

Los médicos Denominan: ____________________________________ Teléfono: ________________________

Dirección: ________________________________ Ciudad: _________________ Estado: ______ Código postal:

Es Médico un Especialista? ☐ Sí ☐ No Si sí, da la especialidad: Ortopédico, el Neurocirujano, Chiropratic, etc.____

Yo por la presente he escogido al médico siguiente de la lista proporcionada a mí por mi empleador:

Médico Escogido: ____

Firma de empleado: ________________________________ La fecha Escogió: ______________________

Una copia de esta forma debe ser proporcionada al empleado. El empleador debe mantener la forma original en el archivo y sobre el pedido Les proporciona una copia a la División de la Compensación de Trabajadores.

Esta forma se requiere a estar en conformidad con Código de Tennessee Anotado§50-6-204.

FORM C-41

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

Division of Workers' Compensation

220 French Landing Dr.
Nashville, Tennessee 37243-1002

WAGE STATEMENT

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

Employee:__________________________ **SSN:** ____________**State File #** _______________________

Insurer Claim #: _______________________ **Date of Injury** _________________________________

In order to determine the correct rate of compensation to be paid to the above injured party, please fill in the schedule below and return it promptly. This information is required by law and no agreement for payment of compensation can be made until it has been received. Please complete 52 weeks prior to date of accident.

Please describe allowances of any character made in lieu of wages that must be deemed a part of employee's earnings: ____

If the average weekly wage is not based on fifty-two weeks of earnings proceeding the date of injury, please show your computation below: ____

WEEK	NO. DAYS	WEEK ENDING		GROSS WAGES	WEEK	NO. DAYS	WEEK ENDING		GROSS WAGES
1					**27**				
2					**28**				
3					**29**				
4					**30**				
5					**31**				
6					**32**				
7					**33**				
8					**34**				
9					**35**				
10					**36**				
11					**37**				
12					**38**				
13					**39**				
14					**40**				
15					**41**				
16					**42**				
17					**43**				
18					**44**				
19					**45**				
20					**46**				
21					**47**				
22					**48**				
23					**49**				
24					**50**				
25					**51**				
26					**52**				
							TOTAL PAID		

Rate per Day _______________ **Rate per Hour**_____________ **Average per Week** _________________

I hereby certify that the above is a true and correct account, as taken from our time books or payroll records, of the wages paid to the above-named injured employee for the periods indicated.

Date _______________ 20____ Employer ____

Name of Preparer & Title ____

Phone, Fax, Email ____

FORM C-31

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Division of Workers' Compensation

MEDICAL WAIVER AND CONSENT

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE DIVISION OF WORKERS' COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. § 50-6-204 AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

I, ________________________________, having filed a claim for workers' compensation benefits, do hereby authorize

____

(Name of Medical Provider)

to furnish to my employer or my employer's representative, and/or the Division of Workers' Compensation any information or written material reasonably related to my work-related injury for which I am claiming compensation.

I further authorize the release of the same information to me or my attorney.

The authorization includes, but is not restricted to, a right to review and obtain copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

A photocopy of the authorization may be accepted in lieu of the original.

Dated: ________________________, 20____.

___________________________________ ___________________________

Patient Social Security last four numbers

____

Witness

FORM C-31 (DOCUMENTO C-31)

DEPARTAMENTO DE TRABAJO Y DESARROLLO LABORAL DE TENNESSEE
División de Indemnización de los Trabajadores

EXONERACIÓN Y CONSENTIMIENTO MÉDICO

Es un crimen proveer información falsa deliberadamente, incompleta o errónea a cualquiera de las partes para una transacción de indemnización de trabajadores con el propósito de cometer fraude. Las penas legales incluyen encarcelamiento, multas y denegación de los beneficios del seguro.

ESTE FORMATO DE AUTORIZACIÓN MÉDICA SOLAMENTE PERMITE AL EMPLEADOR O A LA DIVISIÓN DE INDEMNIZACIÓN DE LOS TRABAJADORES OBTENER INFORMACIÓN MÉDICA A TRAVÉS DE COMUNICACIÓN ORAL O ESCRITA, INCLUYENDO, PERO NO LIMITÁNDOSE A, DIAGRAMAS, EXPEDIENTES, REGISTROS E INFORMES EN POSESIÓN DE UN PROFESIONAL MÉDICO AUTORIZADO POR EL EMPLEADOR, DE ACUERDO CON T.C.A. § 50-6-204, Y UN PROFESIONAL MÉDICO A QUIEN EL EMPLEADOR LE REEMBOLSE POR EL TRATAMIENTO DEL EMPLEADO.

Yo, _________________________________, habiendo presentado una demanda para beneficios de indemnización de trabajadores, por medio de la presente autorizo al doctor

____
(Nombre del profesional médico)

a facilitarle a mi empleador (o al representante de mi empleador) y/o a la División de Indemnización de los Trabajadores cualquier información razonablemente relacionada, o documentos escritos razonablemente relacionada con mi herida derivada de un accidente laboral. Tambien autorizo la distribución de la misma información a mi abogado. La autorización incluye, pero no se restringe a, el derecho a revisar y obtener copias de todos los registros en el historial médico, rayos x, informes de rayos x, diagramas médicos, prescripciones, diagnósticos, opiniones y ciclos de tratamiento.

Se puede aceptar una fotocopia de la autorización en vez de la original.

Fechado: _________________________, 20____.

____________________________________ ____________________________
Paciente Últimas cuatro cifras del número de Seguro Social

____
Testigo

The Division certifies that this Spanish Medical Waiver and Consent (Form C-31) is an exact translation of the English Form C-31.

TENNESSEE WORKERS' COMPENSATION INSURANCE

Employers: The law requires this notice to be conspicuously posted at the employer's place of business so all employees have access to it.

WHO IS REQUIRED TO HAVE WORKERS' COMPENSATION INSURANCE?

All employers with five (5) or more full or part-time employees.
All employers engaged in the mining and production of coal with one (1) or more employees.
All contractors in the construction industry with one (1) or more employees.

To confirm if an employer is subject to the workers' compensation law and if so to obtain the name of the workers' compensation insurance company contact:

____
Name of employer representative authorized to provide information on workers' compensation

____
Telephone number of employer representative to provide information on workers' compensation

____
Address of employer representative to provide information on workers' compensation

WHAT SHOULD AN EMPLOYEE DO IF INJURED AT WORK?

1. Report the injury to the employer immediately. Employer notification is required.

and 2. Select a treating physician from a panel provided by the employer.
To report an injury contact:

____
Name of employer representative to notify in event of a work related injury

____
Telephone number of employer representative to notify in event of a work related injury

____
Address of employer representative to notify in event of a work related injury

WHAT SHOULD AN EMPLOYER DO WHEN AN INJURY IS REPORTED?

1. Immediately complete a First Report of Work Injury form and send it to the workers' compensation insurance company or the third party administrator to be filed with the Tennessee Dept. of Labor and Workforce Development, Workers' Compensation Division.

and 2. Offer a panel of physicians.
The employer shall designate a group of three (3) or more physicians or surgeons not associated together in practice from which the injured employee shall have the privilege of selecting the operating surgeon or the attending physician. If the injury is a back injury, the panel shall be expanded to four (4), one of whom must be a doctor of chiropractic. If a doctor of chiropractic is chosen, chiropractor visits may be authorized for up to twelve (12) visits per back injury. More than twelve (12) visits to such doctor of chiropractic must be specifically approved by the employer or insurance carrier. The provisions for chiropractic care shall not apply to workers' compensation self insurer pools established pursuant to Section 50-6-405(a)(1). If the injury requires the treatment of physician or surgeon who practices orthopedic or neuroscience medicine then the employer may appoint a panel of physicians or surgeons practicing orthopedic or neuroscience medicine consisting of five (5) physicians, with no more than four (4) physicians affiliated in practice together. The employee may select a treating physician or surgeon from the employer panel.

The Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, has staff available to help both employees and employers. For more information contact:

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION
220 FRENCH LANDING DRIVE
NASHVILLE, TENNESSEE 37243-1002
615-532-4812 OR TOLL FREE 1-800-332-2667 OR 1-800-332-2257 (TDD)
www.tennessee.gov/labor-wfd/wcomp.html

LB-0922 (rev. 10/07)

SEGURO DE ACCIDENTES DE TRABAJO DE TENNESSEE

Empleadores: La ley exige que se ponga este aviso en un lugar del negocio del empleador bien visible para que todos los empleados tengan acceso al mismo.

¿QUIÉNES ESTÁN OBLIGADOS A TENER SEGURO DE ACCIDENTES DE TRABAJO?

Todo empleador que tenga cinco (5) o más de cinco empleados de horario completo o de medio horario.

Todo empleador que se dedique a la explotación de minas y la producción de carbón que tenga un (1) empleado o más de un empleado.

Todo empresario de la industria de la construcción que tenga un (1) empleado o más de un empleado.

Para comprobar si un empleador está sujeto a la ley de accidentes de trabajo y si ese fuera el caso, para obtener el nombre de la compañía de seguro de accidentes de trabajo a contactar:

____

Nombre del representante del empleador

____

Número de teléfono del representante del empleador

____

Dirección del representante del empleador

(el nombre, la dirección y el número de teléfono del representante del empleador autorizado a dar información sobre indemnización por accidentes de trabajo)

¿QUÉ DEBE HACER UN EMPLEADO SI SE LESIONA EN EL TRABAJO?

1. Notificar al empleador de la lesión inmediatamente. Es obligatorio notificar al empleador.

y 2. Escoger a un médico que le atienda de la lista que le dé el empleador.
Para notificar una lesión póngase en contacto con:

____

Nombre del representante del empleador

____

Número de teléfono del representante del empleador

____

Dirección del representante del empleador

(el nombre, la dirección y el número de teléfono del representante del empleador autorizado a dar información sobre indemnización por accidentes de trabajo)

¿QUÉ DEBE HACER EL EMPLEADOR CUANDO SE LE NOTIFICA DE UNA LESIÓN?

1. Llenar inmediatamente el formulario Primera Notificación de Accidente de Trabajo y enviarlo a la compañía de seguro de accidentes de trabajo o al administrador del seguro contra tercera persona para que lo registre en el Departamento de Trabajo y Desarrollo Laboral de Tennessee, División de Accidentes de Trabajo.

y 2. Ofrecer una lista de médicos.
El empleador deberá nombrar un grupo de tres (3) médicos o cirujanos o más que no estén afiliados a la misma oficina y de los cuales el empleado lesionado tendrá el privilegio de escoger ya sea el médico que le va a atender o el cirujano que le va a operar. Si la lesión es una lesión de la espalda, la lista aumentará a cuatro (4), entre los cuales habrá un médico quiropráctico, teniendo en cuenta que por cada lesión de la espalda sólo se permitirán doce (12) visitas en total al médico quiropráctico. Si es una lesión que requiere que le atienda un médico o cirujano que ejerce la medicina ortopédica o de neurociencias, entonces el empleador deberá nombrar un grupo de cinco (5) médicos o cirujanos que ejercen la medicina ortopédica o de neurociencias de entre los cuales sólo cuatro (4) pueden estar afiliados a la misma oficina. El empleado puede escoger un médico o cirujano de la lista del empleador para que le atienda.

El Departamento de Trabajo y Desarrollo Laboral de Tennessee, División de Accidentes de Trabajo tiene trabajadores disponibles para ayudar tanto al empleado como al empleador. Si necesita más información, favor de ponerse en contacto con:

DEPARTAMENTO DE TRABAJO Y DESARROLLO LABORAL DE TENNESSEE
DIVISIÓN DE ACCIDENTES DE TRABAJO
220 FRENCH LANDING DRIVE
NASHVILLE, TENNESSEE 37243-1002
615-532-4812 O LLAME GRATIS AL 1-800-332-2667 O AL 1-800-332-2257 (TDD)
www.state.tn.us/labor-wfd/wcomp.html

TENNESSEE FIRST REPORT OF INJURY FORMS PACKET

Tennessee Workers' Compensation First Report of Work Injury – Form C-20

Tennessee Workers' Compensation Agreement Between Employer/Employee Choice of Physician – Form C-42 – English/Spanish

Tennessee Workers' Compensation Wage Statement – Form C-41

Tennessee Worker' Compensation Medical Waiver and Consent – Form C-31 – English/Spanish

Tennessee Workers' Compensation Insurance Posting Notice – Form LB-0922 (rev. 10/07) – English/Spanish

Supervisor's Incident Report

Medical Authorization

Attending Physicians Return to Work Recommendation Record

Job Analysis

Return to Work Log

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SUPERVISOR'S INCIDENT REPORT

☐ Injury(work related) ☐ Incident ☐ Illness (work related)

Employee Name (First, MI, Last)	Social Security Number	Sex ☐ Male ☐ 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	☐ No Lost Time ☐ Date Returned to Work ☐ 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							
☐ Eye	☐ Hip	☐ Head	☐ Foot	☐ Neck	☐ Wrist	☐ Back	☐ Hand
☐ Arm	☐ Toes	☐ Shoulder	☐ Ankle	☐ Fingers	☐ Elbow	☐ Leg	☐ Other

Type of Injury						
☐ Cut/Abrasion	☐ Bruise/Contusion	☐ Foreign Object	☐ Burn	☐ Break	☐ Sprain/Strain	☐ Exposure
☐ Repetitive Motion	☐ Other					

Comments ______________________

Supervisor Signature ______________________ Date ______________

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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) ☐ Recommend his/her return to work with no limitations on _________________________

2) ☐ He/She may return to work on _________________ capable of performing the degree of work checked below with the following restrictions:

☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, 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

☐ **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

☐ **Light Medium Work.** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

☐ **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ **Medium Heavy Work.** Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds

☐ **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds

1. In an 8 hour day patient may:

a) Stand/Walk
☐ None ☐ 1-4 hours ☐ 4-6 hours ☐ 6-8 hours

b) Sit
☐ 1-3 hours ☐ 3-5 hours ☐ 5-8 hours

c) Drive
☐ 1-3 hours ☐ 3-5 hours ☐ 5-8 hours

2. Patient may use hand(s) for repetitive:

☐ Single Grasping

☐ Pushing & Pulling

☐ Fine Manipulation

3. Patient may use foot/feet for repetitive movement as in operating foot controls

☐ Yes ☐ No

4. Patient is able to:

	Frequently	Occasionally	Not at All
Bend	☐	☐	☐
Squat	☐	☐	☐
Climb	☐	☐	☐
Twist	☐	☐	☐
Reach	☐	☐	☐

Other Instructions and/or Limitations Including Prescribed Medications:

The restrictions are in effect until _______________ or until patient is revaluated on _______________

3) ☐ He/She is total incapacitated at this time. Patient will be re-evaluated on_______________.

Physician's Signature Date

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JOB ANALYSIS

Name			Claim Number	
Address			Employer	
Date Hire	Date of Injury		Job Title	Check One ☐ Skilled ☐ Unskilled
Training Required to Learn Job				
Was employee working as a Supervisor ☐ Yes ☐ No	If yes, number of people Supervised		Employee worked: ☐ Alone ☐ Small Group (3-5) ☐ Large Group	
Days worked per week (Circle) M Tu W Th F Sat Sun	Hours worked during week From		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 ☐ Yes ☐ No
If Yes, Specify		

Body Movements

Sitting	%	Standing	%	Walking	%

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							

☐ No lifting required for this job

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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 Work ☐ Inside _____% ☐ Outside _____%	Does Employee Walk on Uneven Ground? ☐ Yes ☐ No
Does Employee Work Around Moving Machinery?	☐ Yes ☐ No
Does Employee Drive Automotive Equipment?	☐ Yes ☐ 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

☐ Job Site Evaluation Done	☐ Narrative
Name(s) of Person(s) Interviewed	Title

Person Completing Analysis	Title	Date

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RETURN TO WORK LOG

Employee Name ______________________ Supervisor ______________________

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

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

Employee Signature ______________________ Date ______________________

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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.

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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 all injuries immediately, in writing if possible, to your employer.
- The law requires you to notify your employer within 30 days of the date of injury, preferably in writing.
- Your employer must complete a First Report of Injury and offer you a panel of doctors for treatment.
- You must select one of the doctors, who becomes the authorized treating doctor and provides treatment at your employer or its insurance carrier's expense.
- A signed Form C42, "Agreement Between Employer/Employee Choice of Physician" must be completed. Your employer must provide you with a copy of the completed form.
- 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 illness 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.
- You must fill out a Form C-20, First Report of Work Injury and file the form with your insurance carrier or administrator within one working day of knowledge of injury. A wage statement should accompany the First Report or be sent to the insurance carrier as soon as possible.
- 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 offer the injured employee a panel of three physicians. You must post the panel so your employees will know who they are allowed to see if they are injured.
- You must obtain from the injured employee a signed C-42, "Agreement Between Employer/Employee Choice of Physician" form. This signed form is the employer's proof that the employee was offered a choice of physicians. A copy of this completed form must be provided to the employee. You must keep the original form on file and upon request provide a copy to the Division of Workers' Compensation.

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- 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.
- Coordinate the return to productive work of employees whose injury or illness causes an interruption in employment, including provision of reasonable accommodations and/or placement assistance if necessary (Case Management).
- You should inform the injured employee of the name and telephone number of the insurance carrier/adjuster.

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.
- Accept or deny the claim within fifteen (15) days of the knowledge of the injury. SUA must notify the employer and the claimant of your decision within fifteen (15) days.
- Issue compensation payment to the claimant no later than fifteen (15) days after notice of injury. All workers' compensation benefits must be issued in a timely manner (on or before due date).
- Send a copy of the First Report and the Notice of First Payment or Notice of Denial to the Division of Workers' Compensation no later than fourteen (14) days after notice of injury.

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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.

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RESOURCES

SUA Insurance – www.suainsurance.com

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

Tennessee Workers' Compensation Division - http://www.state.tn.us/labor-wfd/wcomp.html -
For General Questions 1-800-332-2667 (within Tennessee) or 615-532-4812

Tennessee Workers' Compensation Benefits Information - http://www.state.tn.us/labor-wfd/lsques.html#WCbenrev

Tennessee Workers' Compensation Fraud Section - http://www.state.tn.us/labor-wfd/lsques.html#WCfraud

Tennessee Workers' Compensation Poster - http://www.state.tn.us/labor-wfd/wcinjuryinfo.html

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