Associated Claims Administrators

Dear Employer:

Associated Claims Administrators (ACA) will be administering your Workers' Compensation claims on behalf of National Liability & Fire Insurance Company.

ACA professionals are experienced in Workers' Compensation Law. Please feel free to call our office with any questions you may have regarding your Workers' Compensation concerns.

Early involvement in a claim is important. It is not only cost effective for you, but it also can help the injured employee get proper medical care and return to work as soon as possible. We look forward to working with you to accomplish these goals.

You, the employer, are a vital part of making this happen and listed below are some things you can do:

- **Review the attached list of Frequently Asked Questions.**
- Report all work related injuries to ACA as soon as you are aware of them. Our toll free fax number is 1-800-988-4722.
- You may report all work related injuries to ACA by email at claims@acaworkcomp.com.
- Refer all medical authorization requests to ACA.
- Communicate with your employee and ACA throughout the claim.
- Have some light duty work available for restricted duty.
- Advise ACA when the employee returns to work.

Please keep copies of the attached forms to have on hand if needed.

We look forward to a long and pleasant working relationship with you and your employees.

Please call ACA anytime between 7:00am and 5:00pm Central Time, Monday through Friday if you have any questions regarding Workers' Compensation claims procedures.

Thank you.

Sincerely,

Associated Claims Administrators

Frequently Asked Questions re: Claims

What is the "waiting period"?

Each state regulates the number of days an injured worker must be off work due to a work related injury before compensation (wage) payments may begin. This period is referred to as a "waiting period" and the number of days varies by state law. The State of Tennessee defines the waiting period as 7 days. Compensation payments begin on the 8th day.

Will an injured worker be paid for the days within the waiting period?

An injured worker may receive compensation payments for the number of days off comprising the waiting period, if he or she is out of work due to the injury longer than a specified period of time.

The reimbursement of waiting period for the State of Tennessee is defined as 14 days following the date of disability according to state law. If an injured worker's disability lasts longer than 21 days, he/she will be reimbursed for the 7 day waiting period.

How do we obtain a list of medical providers or the Employers' Posted Panel?

Rules and regulations regarding approved medical providers and/or Employers' Posted Panels for treatment of injured workers vary by state. It is important for every employer to understand how to identify and utilize medical providers and/or Employers' Posted Panels. For assistance obtaining a list of preferred providers and/or help setting up an Employers' Posted Panel, please contact the claims office at (800) 388-6268.

Do we have to provide light duty?

Providing light duty within the guidelines of a medically restricted employee of a compensable claim often shortens the length and reduces the total cost of the claim. While light duty may not be possible for some employers, it is recommended that all employers work to incorporate a light duty/return to work program.

How is the compensation rate calculated?

The compensation rate is 2/3 of the average weekly gross earnings of the injured worker. The number of weeks used for calculating varies by state and is subject to the state's minimum/maximum at the time of accident.

The State of Tennessee uses gross wages for 52 weeks preceding the date of accident to determine the average weekly gross earnings.

How does the claimant obtain their medication?

The injured worker can obtain their medication from any pharmacy. They should provide the pharmacy with the contact information for ACA for further billing instructions and/or approval as provided below:

Associated Claims Administrators, Inc.	Toll Free:	(800) 388-6268
P.O. Box 230848	Fax (Toll Free):	(800) 988-4722
Montgomery AL 36123-0848	Email:	claims@acaworkcomp.com

Can an employer be reimbursed for medical billing they pay?

If the authorized medical billing relates to the compensable claim, the billing will be reviewed for possible reimbursement at the state fee schedule rate.

If we have a deductible can we pay the claims up to the deductible amount?

No. A deductible applies per claim and is set up on a reimbursement basis. That means you, the employer, should file a First Report of Injury on all work related accidents. If our investigation leads to payment of the claim, we will cover costs first dollar and submit one or more invoices to you for reimbursement as payments are made up to the total/maximum per claim deductible amount noted on your policy.

Not all policies have a deductible. Your policy will include a deductible amount on the Workers' Compensation Policy Information Page if your policy has a deductible.

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

CLAIMS ADM/CARRIER

JURISDICTION CLAIM # (STATE FILE #)	CLAIM TYPE CODE ☐ MED ONLY ☐ INDEMNITY ☐ BECAME LOST TIME ☐ BECAME MED ONLY ☐ NOTIFY ONLY ☐ TRANSFER	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).
CLAIMS ADM CLAIM # (INSURER CLAIM #)		
OSHA LOG CASE #		
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	

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	EFF DATE	**EMPLOYMENT STATUS CODE** ☐ FULL TIME/REGULAR ☐ PART TIME ☐ PIECE WORKER ☐ SEASONAL ☐ VOLUNTEER ☐ APPRENTICE FULL TIME ☐ APPRENTICE PART TIME
	SELF INSURED? ☐ YES ☐ NO	EXP DATE	

EMPLOYEE

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

WAGE

WAGE $	PERIOD ☐ HOURLY ☐ WEEKLY ☐ DAILY ☐ 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 ☐ FATHER ____ SISTER TOTAL # DEPENDENTS ☐ WIDOWER ____ DAUGHTER ____ BROTHER ☐ MOTHER ____ SON ____ HANDICAPPED CHILD		
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		ADDRESS LINE 1 AND 2	
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

Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002

FORM C-41

WAGE STATEMENT

EMPLOYEE: _____ SSN: _____ STATE FILE #:_____

Employer _____ Ins Claim # _____ Date of Injury: _____

Please list the wages earned by the employee named above during each of the 52 weeks prior to date of injury, if applicable.

WEEK	WEEK ENDING	GROSS WAGES	WEEK	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	

Date: _____ Name of Preparer and Title _____

TENNESSEE WORKERS' COMPENSATION INSURANCE

POSTING NOTICE

How to Report Work-Related Injuries

What should be done if injured at work?

Employee

1. Immediately **report the injury** to the employer representative named below.
2. **Select a treating physician** from a panel provided by your employer.
3. If you have questions or problems, contact the employer representative or the Bureau of Workers' Compensation.

Employer

1. Complete your company's internal "Workplace Injury form" and **notify your workers' compensation insurance company** immediately, even if you have concerns about the validity of the claim.
2. **Offer a panel of physicians** to the employee via Form C-42 available on the Bureau's website. *In cases of emergency, call an ambulance and provide this form as soon as the injured employee has stabilized.*

_____

*Printed **name and title** of the employer representative to be notified in the event of a work-related injury*

_____

*Printed name of an **alternative employer representative** to be notified in the 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*

The Tennessee Bureau of Workers' Compensation is available to help both employees and employers.

BWC Bureau of WORKERS' COMPENSATION

220 French Landing Dr. 1-B
Nashville, TN 37243-2667

800-332-2667

615-532-4812 *TTD: 800-332-2257*

tn.gov/workerscomp

Workers' Compensation law requires this notice to be posted in a conspicuous place at the work site at all times.

LB-0922 (REV. 4/18) Authorization No. 337545 RDA 10183

SEGURO DE COMPENSACIÓN A TRABAJADORES DE TENNESSEE

PUBLICACIÓN DE AVISO

Cómo informar de lesiones laborales

¿Qué se debe hacer en caso de lesión laboral?

Empleado

1. **Informe** inmediatamente de **la lesión** al representante del empleador indicado aquí abajo.
2. **Seleccione un médico tratante** del panel provisto por su empleador.
3. Si tiene alguna pregunta o problema, comuníquese con el representante de empleadores de la Oficina de Compensación a Trabajadores.

Empleador

1. Complete el formulario interno de su empresa de "Lesión laboral" y **notifique a su aseguradora de compensación a trabajadores** inmediatamente, incluso aunque tenga dudas acerca de la validez de la reclamación.
2. **Ofrezca un panel de médicos** al empleado a través del Formulario C-42, disponible en el sitio web de la Agencia. *En casos de emergencia, llame a una ambulancia y proporcione este formulario en cuanto el empleado lesionado se haya estabilizado.*

_____

Nombre en letra de molde y título *del representante del empleador a ser notificado en caso de una lesión laboral*

_____

Nombre en letra de molde del ***representante del empleador alterno*** *a ser notificado en caso de una lesión laboral*

_____

Número de teléfono *del representante del empleador a ser notificado en caso de una lesión laboral*

_____

Dirección *del representante del empleador a ser notificado en caso de una lesión laboral*

La Oficina de Compensación a Trabajadores de Tennessee está disponible para ayudar a empleados y empleadores.

BWC Bureau of WORKERS' COMPENSATION

220 French Landing Dr. 1-B
Nashville, TN 37243-2667

800-332-2667

615-532-4812 *TTD: 800-332-2257*

tn.gov/workerscomp

La ley de Compensación a Trabajadores exige que se publique este aviso en un lugar visible en el centro de trabajo en todo momento.

LB-0922 (REV. 4/18) Autorización No. 337545 RDA 10183

FORM C-42

TENNESSEE
BUREAU OF WORKERS' COMPENSATION

EMPLOYEE'S CHOICE OF PHYSICIAN
Medical Panel

Employer

- List at least three physicians and provide this panel to employee upon the report of a workplace injury.
- Keep the completed original form on file and send a copy to the employee for their records.
  - Do *not* send this form to the State unless requested.

Employee

- Fill out the bottom portion of this form to indicate which physician you choose.
  - If you refuse to accept medical services from the chosen physician, your rights to benefits may be delayed.
  - Traveling more than 15 miles (one way) to (or from) medical treatment? Employees may seek reimbursement of their travel expenses from the insurance carrier.
- **Send** completed form **back to your employer**.

TO BE COMPLETED BY THE **EMPLOYER:**

Employee Name _____ Date Panel Provided _____

Employer _____ Date of Injury _____

Employer Contact _____ Phone _____ Email _____

Physician 1	**Physician 2**	**Physician 3**
Name _____	Name _____	Name _____
Phone _____	Phone _____	Phone _____
Address _____	Address _____	Address _____
_____	_____	_____
City _____	City _____	City _____
State _____ Zip _____	State _____ Zip _____	State _____ Zip _____
Is Telehealth available with Physician #1? Yes ____ No ____	Is Telehealth available with Physician #2? Yes ____ No ____	Is Telehealth available with Physician #3? Yes ____ No ____
If yes, web address	If yes, web address	If yes, web address
_____	_____	_____

(Optional) Telehealth-Only **Physician 4** Name _____ Phone _____

Telehealth Provider email address _____ Web address _____

TO BE COMPLETED BY THE **EMPLOYEE:**

I have selected the following physician from the list provided to me by my employer:

Physician Name _____ Appt Date/Time _____

I select: In-person treatment ____ **or** Treatment by Telehealth ____ Were you offered in-person treatment? Yes ____ No ____

Employee Signature _____ Date _____

FORMULARIO C-42

AGENCIA DE INDEMNIZACIÓN LABORAL DE TENNESSEE

ELECCION DE MEDICO DEL EMPLEADO

Panel Médico

Empleador

- Indique al menos tres médicos y proporcione este panel al empleado siempre que haya informe de una lesión laboral.
- Mantenga el formulario original completado en sus archivos y envíe una copia al empleado para su constancia.
  - No envíe este formulario al Estado, a menos que se lo solicite.

Empleado

- Llene la parte inferior de este formulario para indicar el médico de su elección.
  - Si se niega a aceptar los servicios médicos del doctor elegido, esto podría conllevar a retrasos en sus derechos a beneficios.
  - ¿Tiene que viajar más de 15 millas (ida o vuelta) a (o desde) el tratamiento médico? Los empleados pueden solicitar reembolso de sus gastos de viaje de la aseguradora.
- **Envíe** el formulario completado **a su empleador**.

A SER COMPLETADO POR EL **EMPLEADOR**:

Nombre del empleado _____ Fecha en que se proporcionó el panel _____

Empleador _____ Fecha de la lesión _____

Contacto del empleador _____ Teléfono _____ Correo electrónico _____

Médico 1	**Médico 2**	**Médico 3**
Nombre _____ Teléfono _____ Dirección _____ _____ Ciudad _____ Estado _____ Código postal _____ ¿El médico #1 usa Telesalud? Sí _____ No ____ En caso afirmativo, sitio web _____	Nombre _____ Teléfono _____ Dirección _____ _____ Ciudad _____ Estado _____ Código postal _____ ¿El médico #2 usa Telesalud? Sí _____ No ____ En caso afirmativo, sitio web _____	Nombre _____ Teléfono _____ Dirección _____ _____ Ciudad _____ Estado _____ Código postal _____ ¿El médico #3 usa Telesalud? Sí _____ No ____ En caso afirmativo, sitio web _____

(Opcional) Telesalud solamente **Médico 4** Nombre _____ Teléfono _____

Dirección de correo electrónico del proveedor de Telesalud _____ Sitio web _____

A SER COMPLETADO POR EL **EMPLEADO:**

He seleccionado el siguiente médico de la lista que me proporcionó mi empleador:

Nombre del médico _____ Fecha/Hora de la cita _____

Yo selecciono: Tratamiento en persona ____ **o** tratamiento por Telesalud ____

¿Se le ofreció tratamiento en persona? Sí _____ No ____

Firma del empleado _____ Fecha _____