Berkshire Hathaway
HOMESTATE COMPANIES

# Workers Compensation Claim Kit - Kentucky

BHHC KY Claims Kit Introductory Letter – 07/31/2017 (page 3 of 22)

BHC Requirements for KY Posting Notice – 05/21/2018 (page 4 of 22)

KY Form – Workers' Compensation Notice – 04/09/2009 (page 5 of 22)

KY Form IA-1 – First Report of Injury or Illness – 01/01/2002 (pages 6-8 of 22)

KY Form 106 - Medical Waiver and Consent Form – 07/2003 (page 9 of 22)

BHHC Medical History Request – 02/15/2014 (page 10 of 22)

KY Form 113 – Designation of Physician – 03/12/2003 (pages 11-12 of 22)

KY Form – Calculation Pages Excerpt from AWW-1 – Average Weekly Wage Certification – 01/01/1997 (pages 13-14 of 22)

KY Form 114 – Request for Payment for Services or Reimbursement for Compensable Expenses (page 15 of 22)

BHHC General Employee Accident Report – 02/15/2014 (page 16 of 22)

BHHC General Supervisor Accident Report – 02/15/2014 (page 17 of 22)

BHHC General Witness Accident Report – 02/15/2014 (page 18 of 22)

BHHC Express Scripts First Fill Form (English & Spanish) – 12/2018 (pages 19-20 of 22)

BHHC Workers' Compensation Fraud Posters (English & Spanish) – 08/10/2017 (pages 21-22 of 22)

Berkshire Hathaway HOMESTATE COMPANIES

P.O. Box 881236, San Francisco, CA 94105 | Phone: (888) 495-8949 | bhhc.com

Dear Policyholder:

Thank you for placing your workers compensation coverage with Berkshire Hathaway Homestate Companies (BHHC). We look forward to working with you to fulfill all your workers compensation needs.

Enclosed you will find documentation necessary for the processing and administration of a claim in the event of a workplace injury, as well as important information regarding workers compensation requirements for your state (i.e. posting notices, compliance laws, etc). Please utilize the documents included to collect valid information regarding the injured employee and incident, and send the documents in when reporting the claim or upon request. Any completed document should be sent directly to BHHC using mail, e-mail, or fax. The assigned claims professional will forward necessary documentation onto the appropriate state entity.

It is critical that you promptly report all new claims using one of the following methods:

| | |
|---|---|
| **Online:** | 1. Go to our website: www.bhhc.com<br>2. Highlight “Workers Comp” in the menu<br>3. Highlight “Claims Center”<br>4. Click “Report a Claim” |
| **Phone:** | (800) 661-6029 |
| **Fax:** | (800) 661-6984 |
| **E-mail:** | newclaim@bhhc.com |

Kentucky state law requires employers to report every industrial injury or occupational disease claim to their workers compensation carrier immediately.

State law also requires that employers authorize initial medical treatment within 24 hours of knowledge that an occupational injury of illness has been sustained or reported, regardless of the legitimacy of the claim. Failure to comply may result in the loss of “medical control” and a significant increase in the potential claim cost.

We will attempt to contact you and the injured worker within 24 hours of receiving the First Report of Injury. Your cooperation in allowing the injured employee to speak with one of our Claims Professionals is appreciated.

Should you have any questions regarding the contents of this kit, a claim, or claim reporting, please contact our Customer Care Center at (888) 495-8949. Questions regarding your insurance policy or coverage should be directed to your broker or agent. We thank you for choosing BHHC as your workers compensation carrier and look forward to providing you superior customer service and compassionate care for your injured workers.

BERKSHIRE HATHAWAY HOMESTATE COMPANIES

# WORKERS' COMPENSATION POSTING REQUIREMENTS

**Workers' Compensation Notice Poster**

- Post in one or more conspicuous places at your main business office and any company locations where employees report for payroll and other personal matters
- Must contain the insurance carrier's name and contact information and the policy number and effective dates
- The Poster must be printed on at least 8.5" x 11" paper
- Text must appear in at least 12-point font size

**To complete the form, please enter the following information in the spaces provided:**

- Your company name and address
- Name of your designated insurer carrier
- Your policy number and the policy effective dates (start and end)
- Indicate whether or not you participate in a Managed Care Plan
    - If you ae participating, include:
        - Name of the plan
        - Plan representative and their phone number

For your convenience, the Medical Provider Network (MPN) information and our other contact information has been entered on the Poster. Please note, the form fields are designed to populate text meeting the statutory font-size requirement.

*(Kentucky Revised Statutes § 342.610(6) and 803 Kentucky Administrative Regulations 25:200)*

**COMMONWEALTH OF KENTUCKY**

# WORKERS' COMPENSATION NOTICE

**Employees of this business are covered by the Kentucky Workers' Compensation Act (KRS Chapter 342). Conspicuous posting of this Notice is required by law.**

**Employer Name:**
**Address:**
**Workers Compensation Carrier (or third party administrator):**
**Policy #:** **, effective** **to**
**Address:** PO Box 881716, San Francisco, CA 94188
**Telephone:** 800-661-6029 **, Contact Person** Mr. Dustin Puntney

**EMPLOYEES: IF INJURED – NOTIFY your supervisor IMMEDIATELY; when possible Notice should be in writing. FAILURE to notify your supervisor could result in denial of benefits. OBTAIN MEDICAL CARE. Your employer must pay for ALL NECESSARY MEDICAL CARE to treat a workplace injury. The employee may select the physician or medical facility to render care. If the employer is enrolled in an approved Managed Care Plan employee selection of physicians is LIMITED to the Approved Provider Network, except in certain emergencies. FOR INJURIES REQUIRING CONTINUING CARE the EMPLOYEE MUST DESIGNATE A TREATING PHYSICIAN, a form to do so will be furnished by your employer or its insurance carrier.**

**This employer IS ☐ IS NOT ☐ participating in a Managed Care Plan for medical care. The name of the Managed Care Plan is , its representative is , phone number .**

**DISABILITY BENEFITS to replace wages lost due to a workplace injury are payable under the Workers Compensation Act after seven (7) day of disability. A CLAIM MUST BE filed with the Department of Workers' Claim WITHIN TWO YEARS of the date of injury, or last payment of temporary total disability benefits.**

**NEED ASSISTANCE? Contact your employer's claim representative. If your questions about workers' compensation rights are not promptly answered call THE KENTUCKY DEPARTMENT OF WORKERS CLAIMS at 1-800-554-8601 to speak to an Ombudsman or Workers' Compensation Specialist.**

**EMPLOYER SUPERVISORS – NOTIFY MANAGEMENT IMMEDIATELY OF ALL INJURIES SO THAT TIMELY REPORT CAN BE MADE AS REQUIRED BY LAW.**

**04/09/09**

# WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #

INDUSTRY CODE | EMPLOYER FEIN | PHONE #

## CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN | POLICY/SELF-INSURED NUMBER | ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

## EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE

ADDRESS (INCL ZIP)

SEX

☐ MALE
☐ FEMALE
☐ UNKNOWN

MARITAL STATUS

☐ UNMARRIED SINGLE/DIVORCED
☐ MARRIED
☐ SEPARATED
☐ UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE | # OF DEPENDENTS | NCCI CLASS CODE

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER: | DAYS WORKED/WEEK | FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO | DID SALARY CONTINUE? ☐ YES ☐ NO

## OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE ☐ CANNOT BE DETERMINED ☐ AM ☐ PM | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO | TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK | IF FATAL, GIVE DATE OF DEATH | WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO | WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)

INITIAL TREATMENT

☐ NO MEDICAL TREATMENT
☐ MINOR: BY EMPLOYER
☐ MINOR CLINIC/HOSP
☐ EMERGENCY CARE
☐ HOSPITALIZED > 24 HOURS
☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

## OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER

 

## EMPLOYER'S INSTRUCTIONS

**DO NOT ENTER DATA IN SHADED FIELDS**

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

| | | | |
|---|---|---|---|
| Full-Time | On Strike | Unknown | Volunteer |
| Part-Time | Disabled | Apprenticeship Full-Time | Seasonal |
| Not Employed | Retired | Apprenticeship Part-Time | Piece Worker |

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

**EMPLOYER'S INSTRUCTIONS – cont'd**

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

FORM 106
ADOPTED JULY 2003

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
CLAIM NO:_____

# MEDICAL WAIVER AND CONSENT

I, _____ having filed a claim for workers' compensation benefits, do hereby waive any physician-patient, psychiatrist-patient, or chiropractor-patient privilege I may have and hereby authorize any health care provider to furnish to myself, my attorney, my employer, its workers' compensation carrier or its agent, the Division of Workers' Compensation Funds, the Uninsured Employers' Fund, or Administrative Law Judge any information or written material reasonably related to my work-related injury occurring on or about _____ any medical information relevant to the claim including past history of complaints of, or treatment of, a condition similar to that presented in this claim or other conditions related to the same body part.

Such information is being disclosed to the purpose of facilitating my claim for Kentucky workers' compensation benefits.

I understand I have the right to revoke this authorization in writing at any time, by sending written notification to each individual health care provider, but such revocation will not have any affect on actions taken prior to revocation. Moreover, inasmuch as KRS 342.020(8) requires a medical waiver to be executed, revocation may result in suspension or delay of the workers' compensation claim.

I understand that no medical provider may condition treatment or payment on whether I sign this medical waiver; however, I further understand that failure to sign this medical waiver may result in suspension or delay of the workers' compensation claim.

I understand that the information used or disclosed pursuant to this medical waiver may be subject to re-disclosure by the recipient.

This authorization shall remain valid for 180 days following its execution. A photocopy of the authorization may be accepted in lieu of the original.

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

Signed at _____, Kentucky, this _____ day of _____, 20_____.

_____
Signature of Patient Or Personal Representative

Social Security Number: _____

_____
Witness Signature

_____
Description Of Personal Representative's Authority

## KENTUCKY WORKERS' COMPENSATION AND HIPAA

On April 14, 2003, the federal Health Insurance Portability and Accountability Act [HIPAA] privacy regulation will take effect. This regulation limits the situations in which medical providers may release patient information, unless the information is necessary for the purpose of treatment, payment, or health care operations. Moreover, it is important to note that disclosures for workers' compensation are in most instances exempt from HIPAA privacy requirements. The exact wording is as follows: "A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation…"

Since HIPAA defers to state law regarding disclosures relating to workers' compensation, it is important for claimants and medical providers to know what Kentucky law requires for disclosure of patient information. An employee who reports a work injury or who files for workers compensation benefits must "execute a waiver and consent of any physician-patient, psychiatrist-patient, or chiropractor-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation." KRS 342.020 (8). Kentucky law further states that once this Form 106 is signed, any health care provider "shall, within a reasonable time after written request by the employee, employer, workers' compensation insurer [or its agent or assignee], special fund, uninsured employers' fund, or the administrative law judge, provide the **requesting party** with any information or written material reasonably related to any injury or disease for which the employee claims compensation."

Once the Form 106 is signed, health care providers may disclose information as set out in Kentucky law. Another section of the regulation allows release of information pursuant to an administrative or judicial order or subpoena, provided that there has been a reasonable effort to notify the injured worker [or his attorney] that such a request has been made. Should there be questions regarding disclosures pursuant to this form, appropriate legal counsel should be consulted or you can contact the Department of Workers' Claims at 1-800 554-8601.

Berkshire Hathaway HOMESTATE COMPANIES

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: (800) 661-6029 • FAX: (415) 675-5469

# MEDICAL HISTORY REQUEST

**Employee Name:** _____ **Date of Injury:** _____
**Employer Name:** _____ **Completion Date:** _____

Please complete this form by providing your medical history for the past 5 years. This will help ensure that we are able to provide all of your medical records to your current treating physician for you to receive the proper care for your work injury.

Thank you for your cooperation.

**Past Injuries, Disabilities, or Other Medical Conditions**

| |
|---|
| |

**Hospitalizations**

| HOSPITAL NAME, ADDRESS AND PHONE | DATES ADMITTED |
|---|---|
| | |
| | |
| | |
| | |

**Treating Physicians or Groups**

| DOCTOR OR GROUP NAME, ADDRESS AND PHONE | DATES OF TREATMENT |
|---|---|
| | |
| | |
| | |
| | |

**Form 113**
Designation of Physician
Revised 03-12-03

**Two-Sided Form**

COMMONWEALTH OF KENTUCKY
OFFICE OF WORKERS' CLAIMS
Claim No. _____

## NOTICE OF DESIGNATED PHYSICIAN

EMPLOYEE: _____
Name

_____
Street Address

_____ ( ) _____
City, State, Zip Telephone Number

_____ _____
Date of Birth Social Security Number

EMPLOYER AT TIME OF INJURY OR LAST EXPOSURE:

_____
Name

_____
Street Address

_____
City, State, Zip

NATURE OF INJURY OR OCCUPATIONAL DISEASE: _____

_____

DATE OF INJURY OR LAST EXPOSURE: _____

FIRST DESIGNATED PHYSICIAN:

_____
Name

_____
Street Address

_____ ( ) _____
City, State, Zip Telephone Number

Accepted by: _____

**MEDICAL INFORMATION RELEASE:** I hereby waive any privilege I may have to restrict the release of information or written material reasonably related to the work-related injury/disease for which I have sought treatment, and I consent to the release of this information or written material to the medical payment obligor, my employer, Special Fund, Uninsured Employers' Fund, or attorneys representing me or any of the parties named above.

_____ _____
Date Employee Signature

MEDICAL PAYMENT OBLIGOR:

_____
Name Of Obligor

_____
Representative

_____
Street Address

_____ ( ) _____
City, State, Zip Telephone Number

**This form identifies the designated physician and must be returned to the medical payment obligor within ten (10) days after treatment begins. An identification card will be provided to the employee, and that card should be presented when medical treatment is required.**

Notice: The Workers' Compensation Act requires the employer to pay for the medical services reasonably necessary for cure and relief from the effects of a workplace injury or disease.

The employee may choose the physician (including chiropractors, etc.) who treats him as "designated physician." The designated physician is responsible for the coordination of the employee's medical care and may refer the patient to consulting or treating physicians as required. Except in an emergency, all treatment must be performed by or on referral from the designated physician. The employee may not change his designated physician more than once without the medical payment obligor's consent.

Inquiries shall be made to the listed representative of the medical payment obligor.

This form is not advance authorization from the workers' compensation medical payment obligor for medical services.

**Claimant's Name:** _____

**Claim Number:** _____

| **Weeks Worked** **Month/Day/Year** | **# of Regular** **Hours Worked** | | **# of Overtime** **Hours Worked** | | **Regular** **Hourly Rate** | | **Weekly Wage** |
|---|---|---|---|---|---|---|---|
| 1. | _____ | + | _____ | x | _____ | = | _____ |
| 2. | _____ | + | _____ | x | _____ | = | _____ |
| 3. | _____ | + | _____ | x | _____ | = | _____ |
| 4. | _____ | + | _____ | x | _____ | = | _____ |
| 5. | _____ | + | _____ | x | _____ | = | _____ |
| 6. | _____ | + | _____ | x | _____ | = | _____ |
| 7. | _____ | + | _____ | x | _____ | = | _____ |
| 8. | _____ | + | _____ | x | _____ | = | _____ |
| 9. | _____ | + | _____ | x | _____ | = | _____ |
| 10. | _____ | + | _____ | x | _____ | = | _____ |
| 11. | _____ | + | _____ | x | _____ | = | _____ |
| 12. | _____ | + | _____ | x | _____ | = | _____ |
| 13. | _____ | + | _____ | x | _____ | = | _____ |
| | | | | | **Total:** | | **$** _____ |
| | | | | | **÷ By 13 weeks** | | |
| | | | | | **=** | | **$** _____ |
| 14. | _____ | + | _____ | x | _____ | = | _____ |
| 15. | _____ | + | _____ | x | _____ | = | _____ |
| 16. | _____ | + | _____ | x | _____ | = | _____ |
| 17. | _____ | + | _____ | x | _____ | = | _____ |
| 18. | _____ | + | _____ | x | _____ | = | _____ |
| 19. | _____ | + | _____ | x | _____ | = | _____ |
| 20. | _____ | + | _____ | x | _____ | = | _____ |
| 21. | _____ | + | _____ | x | _____ | = | _____ |
| 22. | _____ | + | _____ | x | _____ | = | _____ |
| 23. | _____ | + | _____ | x | _____ | = | _____ |
| 24. | _____ | + | _____ | x | _____ | = | _____ |
| 25. | _____ | + | _____ | x | _____ | = | _____ |
| 26. | _____ | + | _____ | x | _____ | = | _____ |
| | | | | | **Total:** | | **$** _____ |
| | | | | | **÷ By 13 weeks** | | |
| | | | | | **=** | | **$** _____ |

**Claimant's Name:** _____

**Claim Number:** _____

| **Weeks Worked** **Month/Day/Year** | **# of Regular** **Hours Worked** | | **# of Overtime** **Hours Worked** | | **Regular** **Hourly Rate** | | **Weekly Wage** |
|---|---|---|---|---|---|---|---|
| 27. | _____ | + | _____ | x | _____ | = | _____ |
| 28. | _____ | + | _____ | x | _____ | = | _____ |
| 29. | _____ | + | _____ | x | _____ | = | _____ |
| 30. | _____ | + | _____ | x | _____ | = | _____ |
| 31. | _____ | + | _____ | x | _____ | = | _____ |
| 32. | _____ | + | _____ | x | _____ | = | _____ |
| 33. | _____ | + | _____ | x | _____ | = | _____ |
| 34. | _____ | + | _____ | x | _____ | = | _____ |
| 35. | _____ | + | _____ | x | _____ | = | _____ |
| 36. | _____ | + | _____ | x | _____ | = | _____ |
| 37. | _____ | + | _____ | x | _____ | = | _____ |
| 38. | _____ | + | _____ | x | _____ | = | _____ |
| 39. | _____ | + | _____ | x | _____ | = | _____ |
| | | | | | **Total:** | | **$** _____ |
| | | | | | **÷ By 13 weeks** | | |
| | | | | | **=** | | **$** _____ |
| 40. | _____ | + | _____ | x | _____ | = | _____ |
| 41. | _____ | + | _____ | x | _____ | = | _____ |
| 42. | _____ | + | _____ | x | _____ | = | _____ |
| 43. | _____ | + | _____ | x | _____ | = | _____ |
| 44. | _____ | + | _____ | x | _____ | = | _____ |
| 45. | _____ | + | _____ | x | _____ | = | _____ |
| 46. | _____ | + | _____ | x | _____ | = | _____ |
| 47. | _____ | + | _____ | x | _____ | = | _____ |
| 48. | _____ | + | _____ | x | _____ | = | _____ |
| 49. | _____ | + | _____ | x | _____ | = | _____ |
| 50. | _____ | + | _____ | x | _____ | = | _____ |
| 51. | _____ | + | _____ | x | _____ | = | _____ |
| 52. | _____ | + | _____ | x | _____ | = | _____ |
| | | | | | **Total:** | | **$** _____ |
| | | | | | **÷ By 13 weeks** | | |
| | | | | | **=** | | **$** _____ |

Form 114

# KENTUCKY DEPARTMENT OF WORKERS CLAIMS

Frankfort, Kentucky 40601

## REQUEST FOR PAYMENT FOR SERVICES OR REIMBURSEMENT FOR COMPENSABLE EXPENSES

TO BE FILED WITH THE RESPONSIBLE EMPLOYER OR ITS PAYMENT OBLIGOR

① Name, address and Workers Compensation claim number of Employee for whom services were provided or expenses incurred:

_____

_____

② Specific type and dates of service(s) provided:

| Date(s) | Type of Service(s) |
|---|---|
| | |
| | |
| | |
| | |
| | |

③ Name and address of physician who ordered services: (include written authorization if available)

_____

④ Reasonable value of services, including method of computation: $_____: _____

_____

⑤ Other expenses incurred for cure or relief of a work injury or occupational disease(s):

| Date | Description of Expense(s) | $ Amount | If mileage, no. of miles |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| ------- | ---------- Total | $: | Miles: |

Please attach receipts for all purchased items.

Certification:

I hereby certify that the above services were performed or expenses were incurred for the cure or relief of a work injury or occupational disease sustained by the above employee.

Witness: _____ _____

(Name of Person requesting payment)

Date: _____ Address: _____

Phone no: _____

**NOTICE:**

**Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.**

# EMPLOYEE'S ACCIDENT REPORT

*To be completed by the injured worker*

| | |
|---|---|
| Employee name | |
| Employer name | |

| | |
|---|---|
| Date of accident | |
| Time of accident | |
| Time you began work on day of accident | |
| Location of accident *(specify if off-site address)* | |

| How did the injury occur? What job duties were you performing? Please describe in your own words. |
|---|
| |
| |
| |

| What part(s) of your body was injured (indicating right and/or left)? |
|---|
| |

| Have you sought any medical treatment for these injuries? If so, specify where and when. |
|---|
| |
| |

| Have you ever injured this part of your body before (yes or no)? If so, please describe how and when the previous injury(s) occurred. |
|---|
| |
| |

| What witnesses were present when the accident occurred? Please provide names if applicable. |
|---|
| |

| Who did you report the injury to? When was the injury reported? Please provide name(s) and job title(s). |
|---|
| |
| |

| What did you do after the accident occurred? |
|---|
| |
| |
| |
| |

**The above report is true and correct:**

| **SIGNATURE:** | **DATE FORM COMPLETED:** |
|---|---|
| | |

Berkshire Hathaway HOMESTATE COMPANIES

# SUPERVISOR'S REPORT OF EMPLOYEE ACCIDENT

| | |
|---|---|
| Employee name | |
| Employer name | |

| | |
|---|---|
| Date of accident | |
| Time of accident | |
| Date accident reported | |
| Did the employee report the accident immediately? | **YES** ☐ **NO** ☐ |
| Location of accident *(specify if off-site address)* | |

| How did the injury occur? What job duties was the employee performing? |
|---|
| |
| |
| |

| What part(s) of the employee's body were reported as injured? |
|---|
| |

| Has the employee sought any medical treatment for these injuries? If so, specify where and when. |
|---|
| |
| |

| What witnesses were present when the accident occurred (including self)? |
|---|
| |

| Do you have any reason to question the legitimacy of the accident? If so, please explain: |
|---|
| |
| |

**Indicate working conditions present that led to accident (please check all that apply):**

- ☐ Unused/unavailable lifting equipment
- ☐ Unused/unavailable PPE (gloves, hardhat, goggles, etc.)
- ☐ Unused/unavailable sharps container
- ☐ Unguarded or improperly guarded equipment
- ☐ Electrical exposure
- ☐ Obstructed view
- ☐ Lack of training
- ☐ Defective tools or equipment
- ☐ Wet/slippery floor
- ☐ Poor housekeeping
- ☐ Interaction with co-worker
- ☐ Interaction with patient or resident
- ☐ Interaction with customer
- ☐ Chemical exposure
- ☐ Motor vehicle accident
- ☐ Other: _____

| What changes could be made to eliminate or reduce the hazard(s) identified above? |
|---|
| |
| |
| |

**The above report is true and correct:**

| **Prepared by:** | **Title:** | **Date prepared:** |
|---|---|---|
| | | |

Berkshire Hathaway HOMESTATE COMPANIES

# WITNESS' REPORT/STATEMENT OF EMPLOYEE ACCIDENT

| | |
|---|---|
| Employee name | |
| Witness name & phone number | |
| Witness Address | |

| | |
|---|---|
| Date of accident | |
| Time of accident | |
| Location of accident *(specify if off-site address)* | |

| Did you witness the above-reported accident? If so, how did the injury occur? What job duties was the employee performing? |
|---|
| |
| |
| |

| What part(s) of the employee's body were injured? Describe the type of injury (strain, bruise, etc.) |
|---|
| |

| What did the injured employee say at the time of injury? Did the injured employee complain of pain at the time of injury? If they complained of pain, please specify the body part(s). |
|---|
| |
| |

| What did the employee do after the accident occurred? |
|---|
| |
| |

| Were any other witnesses present at the time of the accident? If so, please list them below. |
|---|
| |
| |

**The above report is true and correct:**

| **Signature of witness:** | **Date signed:** |
|---|---|
| | |

*NOTE: Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties.*

myMatrixx
An Express Scripts Company

## To the Injured Worker:

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

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 800.945.5951.

## Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame al Centro de Contacto para Atención a Clientes de Express Scripts, al 800.945.5951.

## To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of $150. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call Express Scripts at 888.786.9640.

### Pharmacy Processing Steps

Step 1: Enter BIN number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

**Express Scripts**

**ID#:** _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

**Date of Injury:** _____/_____/_____
MM/DD/YYYY

**G3YA**

**Group #:** _____

**Employee Date of Birth:** _____/_____/_____

**Thank you** for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

*Please see other side for a list of participating retail network pharmacies.*

**To the Supervisor:** Please fill in the information requested for the injured worker.

### Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

**Employer Name**

_____

# Participating Retail Network Pharmacies

myMatrixx
An Express Scripts Company

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Walmart
Wegmans
Weis
Winn Dixie

Berkshire Hathaway
HOMESTATE COMPANIES

# $1000 Reward!

## For information leading to the arrest and conviction of any co-worker, health care professional, or attorney representing a fraudulent workers compensation claim to Berkshire Hathaway Homestate Companies (BHHC)*

In most states, it is a felony to make or cause to be made a knowingly false or fraudulent material statement in order to obtain workers compensation benefits. BHHC believes that any party engaging in such fraud should be prosecuted to the fullest extent of the law, including jail sentences.

Please do your part to help! Putting criminals out of operation benefits all of us, including keeping your employer's premium rates reasonable.

**Call our toll-free fraud hotline immediately if you have information on a fraudulent claim:**

# 1 (800) 300-JAIL

**BHHC Workers Compensation Division • Representing Financial Strength & Integrity**

*Maximum reward of $1,000 per conviction. In the event that more than one individual submits information regarding the same fraudulent claim, BHHC will equally divide the reward among those providing information used in obtaining the conviction. BHHC reserves the right to determine what information, if any, will be provided to the appropriate law enforcement agency. Criminal prosecutions are the sole responsibility of the authorities and may or may not be pursued at their discretion. *Any issues regarding the intrepretation of this policy shall be resolved by BHHC at their sole discretion. Program subject to change or termination without prior notice.*

Berkshire Hathaway
HOMESTATE COMPANIES

# $1000 RECOMPENSA!

## INFORMACIÓN QUE LLEVA AL ARRESTO Y A LA CONDENA DE CUALQUIER COMPAÑERO DE TRABAJO, PROFESIONAL DE CUIDADO MEDICO, O ABOGADO QUE REPRESENTE UN RECLAMO FRAUDULENTO EN CONTRA DE BERKSHIRE HATHAWAY HOMESTATE COMPANIES*

En la mayoría de los estados es un delito grave hacer que haga una declaración de material fraudulento para obtener beneficios de Compensación al Trabajador. Berkshire Hathaway Homestate Companies cree que cualquier persona que se involucre en tal fraude debe ser procesado con todo el rigor de la ley, incluyendo SER SENTENCIADO A LA CARCEL.

Ayúdenos de su parte. El poner a estos delincuentes fuera de operaciones nos beneficia a todos, incluso esto ayuda a mantener los réditos bajos de la aseguranza de su empleador.

**Si usted tiene información sobre un reclamo fraudulento por favor llame de inmediato a nuestra LINEA GRATUITA DE FRAUDE.**

# (800) 300-JAIL

BHHC Workers Compensation Division • Representing Financial Strength & Integrity

*La recompensa máxima es de $1,000 por convicción. En caso de que más de una persona presente informaciones sobre la misma demando fraudulenta. Berkshire Hathaway dividirá la recompensa por partes iguales entre aquellas persones que aportaron informaciones para obtener la convicción. Berkshire Hathaway se reserva el derecho de determinar qué informacion presentará a la agencia judicial correspondiente. El proceso de crímenes es la responsibilidad exclusiva de las autoridades, que pueden decidir si el proceso debe entablarse or no. Cualquier disputa que pudiera surgir en la interpretación de esta ofreta será resuelta por la propia Compañia de Seguros Berkshire Hathaway. Este programa está sujeto a cambios a cancelación sin aviso previo.