



Berkshire Hathaway
HOMESTATE COMPANIES

Workers Compensation Division™

Workers Compensation State Claim Kit

Pennsylvania



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P.O. Box 881236 San Francisco, CA 94188
(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 contact methods listed to the right.

Pennsylvania state law recommends employers report every industrial injury or occupational disease claim to their workers compensation carrier as soon as possible or within five days of employer knowledge of injury.

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

Contact Information

Online

[bhhcpolicyholder.bhhc.com/
Client/External/Claims](http://bhhcpolicyholder.bhhc.com/Client/External/Claims)

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com



Workers Compensation Posting Requirements

Form LIBC-500 - Workers' Compensation Insurance Posting:

- Post in one or more conspicuous places readily accessible to all employees at all business locations and work sites
- Must be posted in the areas used for the treatment or administration of first aid to injured employees
- Must contain the insurer/carrier contact information
- Print on 8.5" x 11" paper
- Text must be in at least 11-point font-size

Information Needed for this Form

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

- Your company name
- Date posted
- Name of your designated insurance company
- The Bureau Code assigned to your designated insurance company
 - The Bureau publishes a listing Bureau Codes assigned to authorized insurers at dli.pa.gov/Businesses/Compensation/WC/insurance/Pages/Bureau-Code-Listings.aspx

For your convenience, 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.

(Pennsylvania Workers' Compensation Act § 305(e))

Requirements For Workers' Compensation Information Document:

- Must be provided to all employees:
 - At the time of hire
 - Immediately after a work accident or injury or as soon as possible thereafter
- Print on 8.5" x 11" paper
- Text must be in at least 11-point font-size
- Please note, the text of this document meets the statutory font-size requirement.

(34 Pennsylvania Administrative Code § 121.3b)

Information Needed for this Form

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

- Location Name
- Name of an employer representative to provide copies of panel list
- Physician and provider contacts including: physician name, specialty, clinic name, address, and phone

(34 Pennsylvania Administrative Code § 127.754)

The name, address and telephone number of your employer's workers' compensation insurance company, third-party administrator (TPA), or person handling workers' compensation claims for your company, are shown below.

Employer Name: _____ **Date Posted:** _____

IF INSURED:
(Complete all applicable spaces)

**IF SOMEONE OTHER THAN INSURER IS
HANDLING CLAIMS:**
(Complete all applicable spaces)

Name of Insurance Company:

Name of TPA (Claims administrator):

Address: _____

Address: _____

Telephone Number: _____

Telephone Number: _____

Insurer Code: _____

IF SELF-INSURED
(Complete all applicable spaces)

**IF SOMEONE OTHER THAN SELF-INSURER IS
HANDLING CLAIMS:**
(Complete all applicable spaces)

Name of person handling claims at
the self-insured:

Name of TPA (Claims administrator):

Address: _____

Address: _____

Telephone Number: _____

Telephone Number: _____

Insurer Code: _____

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information
Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
PA Relay 7-1-1

Email
ra-li-bwc-helpline@pa.gov



Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

WORKERS' COMPENSATION INFORMATION

- ✓ The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.
- ✓ Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.
- ✓ **You should report immediately any injury or work-related illness to your employer.**
- ✓ Your benefits could be delayed or denied if you do not notify your employer immediately.
- ✓ If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.
- ✓ The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at:

Bureau of Workers' Compensation

1171 South Cameron Street,

Room 103,

Harrisburg, Pennsylvania 17104-2501

Telephone number within Pennsylvania (800) 482-2383

Telephone number outside of this Commonwealth (717) 772-4447

TTY (800) 362-4228 (for hearing and speech impaired only)

www.state.pa.us, PA Keyword: workers comp

I have read this document and fully understand its entire contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received. I understand that I have a right to receive a copy of this acknowledgment upon my request.

Employee Name

Employee Signature

Date



Location

Notice: Medical Treatment For Your Work Injury Or Occupational Illness

Your employer has selected a list of six or more physicians and other health care providers who are available to treat your work-related injuries and illnesses during the first 90 days of treatment. This list is posted below for you to review. Also, you may get a copy of this list from .

If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under Section 306(f.1)(1)(i) of the Workers' Compensation Act regarding your medical treatment. These rights and duties are summarized below.

Medical Treatment: During The First 90 Days

- You have the RIGHT to receive reasonable and necessary medical treatment for your work injury or occupational illness. Your employer must pay for the treatment, as long as the treatment is by one of the listed providers.
- If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider of your choice. If that opinion is different from the opinion of the listed provider, you have the RIGHT to choose which course of treatment to follow. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.
- You have the RIGHT to choose which of the listed providers will treat you for your work injury or illness.
- You have the DUTY to visit one or more of the listed providers for the first 90 days of treatment for your work injury or illness if you expect your employer to pay for the medical treatment you receive.
- You have the RIGHT to switch among any of the listed providers when you receive treatment; and if a listed provider refers you to a provider not on your employer's list, you have the RIGHT to receive treatment from the referral provider.
- If you seek treatment for your work injury or illness from a provider who is not on the list, your employer may not have to pay for this medical treatment during this 90-day period. Therefore, you should talk to your employer before seeking treatment from a provider who is not on the list.
- If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider

Important

The requirements your employer must meet to have a valid list of at least six providers are shown on the reverse side of this form. If the list does not meet these requirements, it is not a valid list, and you have the right to seek medical treatment for your work injury or occupational illness from any health care provider of your choice.

Medical Treatment: After The First 90 Days

- You have the RIGHT to receive treatment from any physician or other health care provider of your choice, whether or not they are listed by your employer. Your employer must pay for this treatment as long as it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.
- You have the DUTY to notify your employer if you receive treatment from a physician or other health care provider who is not listed by your employer. You must notify your employer within five days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for the treatment received until you have given this notice.



BHHC PA Treating Physician Designation

Your signature on this form indicates that you have been informed of and you understand these rights and duties. If you have questions, be sure you have your rights and duties explained to you before signing this form.

I have been informed of my medical treatment rights and duties with regard to work-related injuries and occupational illnesses. This notice was presented to me at [check one]:

Time Of Hire When I Was Injured Other

Employee

Date

Employer Representative

Date

List of Physicians & Healthcare Providers

Physician Name

Specialty

Clinic Name

Address

Phone

Requirement For Employer's List of Health Care Providers

- 1 There must be at least six health care providers on the list, but there may be more than six listed.
- 2 At least three of the health care providers on the list must be physicians.
- 3 No more than four of the health care providers on the list may be coordinated care organizations (CCOs).
- 4 The names, addresses, phone numbers and areas of medical specialties of all health care providers must be included on the list.
- 5 The health care providers on the list must be geographically accessible and must have specialties that are appropriate based on the anticipated work-related medical problems of the employees.
- 6 Your employer must specify on the list if any of the health care providers on the list are employed, owned or controlled by your employer or its workers' compensation insurance company.

Health Care Provider Qualifications

Your employer's list of health care providers must meet all of the above requirements. If the list does not meet all of these requirements, you do not have to choose a medical provider from the list. Instead, you have the right to seek medical treatment with any health care provider of your choice.

Bureau Of Workers' Compensation Helpline Information Center

[Long Distance Calls Inside PA](#)
(800) 482-2383)

[Local and Calls Outside PA](#)
(717) 772-4447



Pennsylvania Medical Provider Panels

Treating physicians can have a significant impact on a claim's medical cost. A key component to controlling these costs and reaching a satisfactory resolution of a claim for all parties involved is ensuring that the claimant receives quality medical care from a competent physician. In the state of Pennsylvania, employers have a single option, in the form of provider panels, for asserting some influence on the selection of the treating physician. Pursuant to PA WC Act § 306(f.1) and 34 Pa. Code § 127.751(a), excluding denied claims and emergencies, the establishment and maintenance of a valid medical provider panel may limit an injured worker's initial physician choice to medical providers designated within the panel for the first 90 days of treatment. The first 90 days of a claim is a crucial period in the life of a claim which may set the tone for the remaining days of a claim. Please note, the failure to authorize initial medical treatment upon notice of an employee's work injury may result in a waiver of panel rights.

This document contains a summary of the essential elements for the creation and maintenance of an enforceable medical provider panel.



Medical Provider Panel Requirements

Notice to Workers

The law requires employers to provide notice of their medical provider panel to all employees. Notice should be given prior to and upon knowledge of an employee's work injury.

Posting

Employers are required to post the panel listing in prominent and readily accessible places at all business locations and work sites. Each panel must include required notices contained within 34 Pa. Code § 127.755(b). Our Medical Provider Panels Poster may be used to comply with the requirements.

POST REQUIREMENTS

- Print on legal sized paper (8.5" x 14")
- Must be posted in the areas used for the treatment or administration of first aid to injured employees

Acknowledgement Form

The use of an acknowledgment form to be signed by all employees to show that they have been notified of the panel and its use is also required. Employees must receive the acknowledgment form at the time of hire and upon notice of accident or injury. Our Medical Provider Panels Poster contains an area to obtain an employee's signature and acknowledgment.

Number of Providers

A panel must include a minimum of at least six health care providers within a reasonable distance.

Healthcare Provider Characteristics

- No more than four providers may be affiliated or within a coordinated care organization.
 - Coordinated care organizations only count as one of the provider choices
- At least three physicians must be included.
 - Specialty Recommendations: orthopedics, neurology, general surgeon, occupational medicine, and ophthalmology.



CAN I ADD A PHYSICIAN THAT IS EMPLOYED BY THE COMPANY I WORK FOR?

Physicians and providers that are employed by, owned, or controlled by the employer may not be used unless such employment, ownership, or control is disclosed.

Panel Period

In general, a valid and enforceable panel restricts a claimant's provider choice to one or more health care providers within a panel for up to 90 days from the of the first visit for the treatment of the work injury or illness.

Panel Maintenance

To guarantee panel validity over time, routine maintenance is recommended. Every six months to a year, each physician or provider on a panel should be contacted to confirm that their contact information is up-to-date and that they are still accepting and treating workers' compensation patients.

Physician Selection And Changes

Excluding denied claims and emergencies, an injured worker is required to select the authorized treating physician from the panel list. Obtain the injured worker's initial selection in writing. Our Treating Physician Designation Form may be used for this purpose.

Please note, exceptions may apply if a physician prescribes a surgical procedure. Please refer to the Medical Provider Panels Poster document for more information.

Injured workers have the right to change to another provider listed on the panel without prior approval.

Claim Procedures

All work accidents and injuries must be reported to us as soon as possible so that we are able to begin the claim investigation promptly. Please have the injured worker complete our Pennsylvania Employee Accident Report.

When reporting the claim, please make sure to provide a copy of your posted physician panel and a copy of the injured worker's signed panel acknowledgment. This allows the Claims Professional to enforce panel use.

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		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)				
			TO						
			CHECK IF APPROPRIATE						
			<input type="checkbox"/> SELF INSURANCE						
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		MARITAL STATUS		OCCUPATION/JOB TITLE		
			<input type="checkbox"/> M MALE <input type="checkbox"/> F FEMALE <input type="checkbox"/> U UNKNOWN		<input type="checkbox"/> U UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> M MARRIED <input type="checkbox"/> S SEPARATED <input type="checkbox"/> K UNKNOWN		EMPLOYMENT STATUS		
PHONE			# OF DEPENDENTS				NCCI CLASS CODE		
RATE PER:		<input type="checkbox"/> DAY WEEK	<input type="checkbox"/> MONTH OTHER:	DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO					<input type="checkbox"/> YES <input type="checkbox"/> NO	
OCCURRENCE/TREATMENT									
TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE () CANNOT BE DETERMINED		<input type="checkbox"/> AM <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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?			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
				WERE THEY USED?			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)			HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)				INITIAL TREATMENT		
							0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 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.

Treating Physician Designation



By signing this document, I acknowledge my employer's posted physician panel. I understand that I must select a medical provider from the panel list to provide medical care for my work injury for the first 90 days of treatment. I also understand that my employer may not be required to pay for any medical treatment that I obtain from a medical provider that is not included on the panel.

I further understand that, if I am not satisfied with the first physician that I select from the panel, I have the right to change to another physician listed on the same panel.

Initial Treating Physician Selection

I hereby select the following physician to provide medical services and treatment for my work injury or illness.

Name

Facility

Address

Phone

I have read this form and fully understand its entire contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received. I understand that I have a right to receive a copy of this document upon my request.

Printed Name

Signature

Date



Claim Number/Número de Reclamo

Date of Injury / Fecha de la Lesión

Employee/Empleado

Date of Birth / Fecha de Nacimiento

I hereby authorize the divisions of Berkshire Hathaway Homestate Companies, their representative or bearer, to review, inspect, copy, and/or photograph any and all of the following documents:

Por este medio autorizo las divisiones de Berkshire Hathaway Homestate Companies, su representante o portador, a revisar, inspeccionar, copiar, y/o fotografiar cualquier y todo de los siguientes documentos:

- 1 Any and all medical records, including but not limited to office and hospital records, laboratory results, diagnostic reports and films, psychiatric records, medical correspondences, doctor's and nurse's notes, and medical histories relevant to my workers' compensation claim. I also hereby give permission to Berkshire Hathaway Homestate Company representatives to contact the attending physicians involved in the treatment of all related conditions.

Cualquier y todo expediente médico, incluyendo pero no limitado, a los expedientes de la oficina y hospitales, resultados de laboratorios y filmas, expedientes psiquiátricos, correspondencia médica, notas de los doctores y enfermeros(as), e historiales médicos relevantes a mi reclamo de compensación de trabajadores. También, por este medio le doy permiso a los representantes de Berkshire Hathaway Homestate Company para comunicarse con el médico tratante envuelto en el tratamiento de todas las condiciones relacionadas.

- 2 All employment and human resource information including but not limited to: hiring and employment records, payroll and income statements, documentation related to this or any other relevant injury and any other information pertinent to providing benefits and services necessary for the completion of this claim.

Toda información del empleo y de recursos humanos, incluyendo pero no limitado a: expedientes de contratación y empleo, declaraciones de nómina e ingresos, documentación relacionada a esta o cualquier otra lesión relevante, y cualquier otra información pertinente que provea los beneficios y servicios necesarios para completar este reclamo.

The released information is required for the following reasons:

La información liberada es requerida por las siguientes razones:

- 1 To provide for adequate preparation, investigation, evaluation, review, and discovery of a claim for workers compensation benefits. Specifically, to determine the causation and the nature and extent of any possible pre-existing, concurrent or aggravating medical conditions with potential medical, legal, or factual implications in the this work-related injury or injuries.

Para proporcionar una preparación, investigación, evaluación, revisión, y descubrimiento adecuado del reclamo de beneficios de compensación de trabajadores. Específicamente, para determinar la causa y la naturaleza y extensión de cualquier posible condición médica pre-existente, concurrente o agravante con potencial médico, legal, o implicaciones fácticas en esta lesión o lesiones relacionadas al trabajo.

- 2 To provide the treating physician, consultant or evaluator with medical information necessary to provide you with the best possible medical care and medical advice.

Para proporcionar al médico tratante, consultor, o evaluador con la información médica necesaria para proporcionarle el mejor cuidado médico posible y consejería médica.



- 3 To facilitate recovery of all benefits paid toward your workers' compensation claim from any third party responsible for this injury.
Para facilitar la recuperación de todos los beneficios pagados por su reclamo de compensación de trabajadores de cualquier tercer parte responsable de esta lesión.
- 4 To ensure that you are accurately compensated for any amount of lost wages, time or resources while undergoing evaluation, treatment and recovery for this injury.
Para asegurar que usted se encuentra compensado correctamente por cualquier cantidad de salarios, tiempo, o recursos perdidos mientras se somete a la evaluación, tratamiento, y recuperación de esta lesión.
- 5 To obtain any information necessary to appropriately determine further actions as a result of the injury or condition and to prevent further issues for you and other employees.
Para obtener cualquier información necesaria para determinar apropiadamente acciones adicionales como resultado de la lesión o condición, y para prevenir problemas adicionales para usted y otros empleados.
- 6 This consent and authorization is effective immediately, and is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate on conclusion of the claim without express revocation.
Este consentimiento y autorización es efectivo inmediatamente, y está sujeto a la revocación del abajo firmante en cualquier momento excepto a la extensión en que se hayan tomado acciones en dependencia con esto de aquí en adelante, y si no es revocado anteriormente, terminará con la conclusión del reclamo si no se presenta una revocación expresa.
A copy or fax is as valid as the original.
Una copia o fax es tan válida como el original.

Names, Addresses, and Phone Numbers of Providers/Nombres, direcciones, y números de teléfonos de los proveedores

I have read this authorization and fully understand its entire contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received. I understand that I have a right to receive a copy of this authorization upon my request.

He leído esta autorización y entendido completamente su contenido en su totalidad. He hecho preguntas sobre todo lo que no estaba claro para mí y estoy satisfecho con las contestaciones que he recibido. Yo entiendo que tengo derecho a recibir una copia de esta autorización una vez lo solicite.

Signature/Firma

Date/Fecha





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	Phone	Date(s) Admitted

Treating Physicians or Groups

Doctor or Group Name, Address	Phone	Dates of Treatment



Employee Accident Report

This form should be filled out by the injured employee.

Name

Employer Name

Date of Accident

Time of accident

Time you began work on day of accident

Address of Accident

City, State

Zip

Offsite? (Y/N)

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 form is true and correct.

Signature

Date Completed

Informe De Accidente Del Empleado

A ser completado por el trabajador lesionado.



Nombre del empleado

Nombre del empleador

Fecha del accidente

Hora del accidente

Hora en que usted empezó a trabajar el día del accidente

Dirección del Accidente

Ciudad, Estado

Código Postal

Fuera del sitio? (S/N)

¿Cómo ocurrió la lesión? ¿Qué deberes del trabajo estaba desempeñando? Por favor, describa en sus propias palabras.

¿Qué parte(s) de su cuerpo resultó(aron) lesionada(s) (indicando derecha y/o izquierda)?

¿Ha buscado algún tratamiento médico para estas lesiones? Si es así, especifique dónde y cuándo.

¿Se ha lesionado anteriormente alguna vez esta parte de su cuerpo (sí o no)? Si es así, por favor, describa cómo y dónde ocurrió(eron) la(s) lesión(es) anterior(es).

¿Qué testigos estuvieron presentes cuando ocurrió el accidente? Por favor, proporcione nombres si es aplicable.

¿A quién informó la lesión? ¿Cuándo fue informada la lesión? Por favor, proporcione nombre(s) y puesto(s).

¿Qué hizo después de ocurrido el accidente?

El informe anterior es verdadero y correcto.

Firma

Fecha En Que Se Completó El Formulario

Supervisor's Report of Employment Accident



Employee Name

Employer Name

Date of Accident

Time of accident

Time you began work on day of accident

Did the employee report the accident immediately?

Address of Accident

City, State

Zip

Offsite? (Y/N)

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:



Supervisor's Report of Employment Accident

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

Unused/unavailable lifting equipment

Obstructed view

Interaction with patient or resident

Unused/unavailable PPE (gloves, hardhat, goggles, etc.)

Lack of training

Interaction with customer

Unused/unavailable sharps container

Wet/slippery floor

Chemical exposure

Unguarded or improperly guarded equipment

Poor housekeeping

Motor vehicle accident

Electrical exposure

Interaction with co-worker

Other:

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

The above form is true and correct.

Prepared by

Signature

Date Completed

Informe Del Supervisor De Accidente De Empleado



Nombre del empleado

Nombre del empleador

Fecha del accidente

Hora del accidente

Fecha en que se informó el accidente

¿Informó el empleado el accidente inmediatamente?

Dirección del Accidente

Ciudad, Estado

Código Postal

Fuera del sitio? (S/N)

¿Cómo ocurrió la lesión? ¿Qué deberes del trabajo estaba desempeñando el empleado?

¿Qué parte(s) del cuerpo del empleado se informaron como lesionadas?

¿Ha buscado el empleado algún tratamiento médico para estas lesiones? Si es así, especifique dónde y cuándo.

¿Qué testigos estuvieron presentes cuando ocurrió el accidente (incluyendo él mismo)?

¿Tiene usted alguna razón para dudar de la legitimidad del accidente? Si es así, por favor, explique:



Informe Del Supervisor De Accidente De Empleado

Indique las condiciones de trabajo presentes que conllevaron al accidente (por favor, marque todas las que apliquen).

Equipo para levantar no usado/no disponible

Vista obstruida

Interacción con paciente o residente

PPE (guantes, casco, gafas, etc.) no usado/no disponible

Falta de capacitación

Interacción con cliente

Contenedor de objetos punzantes no usado/no disponible

Herramientas o equipo defectuosos

Exposición a producto químico

Equipo no resguardado o incorrectamente resguardado

Piso mojado/resbaloso

Accidente de vehículo motorizado

Exposición eléctrica

Mala limpieza

Other:

Interacción con compañero de trabajo

¿Qué cambios se pueden realizar para eliminar o reducir el(los) peligro(s) identificado(s) anteriormente?

El informe anterior es verdadero y correcto.

Elaborado por

Puesto

Fecha de elaboración:



Witness' Report/Statement of Employee Accident

Employee Name

Witness' Name

Witness' Phone Number

Witness' Address

City, State

Zip

Offsite? (Y/N)

Date of Accident

Time of accident

Time you began work on day of accident

Address of Accident

City, State

Zip

Offsite? (Y/N)

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 form is true and correct.

Witness' Signature

Date Completed

Informe del Testigo/Declaración de accidente del empleado



Nombre del Empleado

Nombre del Testigo

Teléfono del Testigo

Dirección del Testigo

Ciudad, Estado

Código Postal

Fuera del Lugar de Trabajo? (Si/No)

Fecha Del Accidente

Hora del accidente

Hora en que comenzó a trabajar el día del accidente

Dirección del accidente

Ciudad, Estado

Código Postal

Fuera del Lugar de Trabajo? (Si/ No)

¿Presenció el accidente? Si es así, ¿cómo ocurrió? ¿Qué deberes laborales estaba realizando el empleado?

¿Qué parte(s) del cuerpo del empleado resultaron lesionadas? Describa el tipo de lesión (tensión, moretón, etc.)

¿Qué dijo el empleado lesionado en el momento de la lesión? ¿El empleado lesionado se quejó de dolor en el momento de la lesión? Si se quejaron de dolor, especifique la(s) parte(s) del cuerpo(s).

¿Qué hizo el empleado después de que ocurrió el accidente?

¿Había otros testigos presentes en el momento del accidente? Si es así, por favor escríbalos aquí.

La forma anterior es verdadera y correcta.

Firma del Testigo

Fecha

»» 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

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



\$1000 REWARD

For information leading to the arrest and conviction of any co-worker, health care professional, or the 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

*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 interpretation of this policy shall be resolved by BHHC at their sole discretion. Program subject to change or termination without prior notice.



\$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.

1 (800) 300-JAIL

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