



Berkshire Hathaway  
HOMESTATE COMPANIES

Workers Compensation Division™

# Workers Compensation State Claim Kit

*Tennessee*



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P.O. Box 881236 San Francisco, CA 94188  
(888) 495-8949  
[bhhc.com](http://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 methods listed to the right.

Tennessee 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

## Report a Claim

### 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](mailto:newclaim@bhhc.com)





# Workers Compensation Posting Requirements

## Form LB-0922 – Tennessee Workers' Compensation Insurance Poster

Post in one or more conspicuous places at all business locations

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

- The name, telephone number, and address of a company employee representative that injured workers should notify regarding workplace accidents and injuries.

(Tennessee Code Annotated § 50-6-407)



# 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.



220 French Landing Dr. 1-B  
Nashville, TN 37243-2667  
**800-332-2667**  
615-532-4812 TTD: 800-332-2257  
[tn.gov/workerscomp](http://tn.gov/workerscomp)

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

# 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 alternativo 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.



220 French Landing Dr. 1-B  
Nashville, TN 37243-2667  
**800-332-2667**  
615-532-4812 TTD: 800-332-2257  
[tn.gov/workerscomp](http://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.*

# 테네시주 상해 보상 보험 게시 통지

## 업무상 상해를 보고하는 방법

근무 중 상해를 입으면 어떻게 해야 하나요?

### 직원

1. 즉시 아래에 기재된 고용주 대리인에게 **상해를 보고하십시오.**
2. 고용주가 제공한 패널에서 **주치의**를 선택하십시오.
3. 궁금한 점이나 문제가 있는 경우, 고용주 대리인 또는 산재 보상국에 문의하십시오.

### 고용주

1. 청구의 유효성에 대한 우려가 있더라도, 회사의 사내 "직장 상해 양식"을 작성하고 **즉시 산재 보험사에 이를 알리십시오.**
2. 산재 보상국 웹사이트에서 제공하는 C-42 양식을 작성하여 직원에게 **의사 패널**을 제공하십시오.  
응급 상황의 경우, 구급차를 부르고 상해를 입은 직원이 안정되는 즉시 본 양식을 제공하십시오.

업무상 상해가 발생한 경우, 통지할 고용주 대리인의 정자체 이름 및 직함

업무상 상해가 발생한 경우, 통지할 대체 고용주 대리인의 정자체 이름

업무상 상해가 발생한 경우, 통지할 고용주 대리인의 전화번호

업무상 상해가 발생한 경우, 통지할 고용주 대리인의 주소

테네시주 산재 보상국은 직원과  
고용주 모두에게 도움을 드릴 수  
있습니다.



220 French Landing Dr. 1-B  
Nashville, TN 37243-2667  
**800-332-2667**  
615-532-4812 TTD: 800-332-2257  
[tn.gov/workerscomp](http://tn.gov/workerscomp)

산재 보상법에 의거하여, 본 통지는 항상 작업장의 눈에 잘 띄는 곳에 게시해야 합니다.



**TENNESSEE BUREAU OF WORKERS' COMPENSATION  
EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS**

<b>CLAIMS ADM/CARRIER</b>	JURISDICTION CLAIM # (STATE FILE #)		CLAIM TYPE CODE <input type="checkbox"/> MED ONLY <input type="checkbox"/> INDEMNITY <input type="checkbox"/> BECAME LOST TIME <input type="checkbox"/> BECAME MED ONLY <input type="checkbox"/> NOTIFY ONLY <input type="checkbox"/> TRANSFER		<p>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.</p> <p>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.</p> <p>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).</p>				
	CLAIMS ADM CLAIM # (INSURER CLAIM #)		CARRIER FEIN						
	OSHA LOG CASE #		FEIN OF CLMS ADM						
	NAME OF INSURANCE CARRIER		CLMS ADJ PHONE #						
	CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)		CITY					STATE	ZIP
	CLAIMS ADJUSTER NAME		CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2						
<b>E MPLOYER</b>	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		
<b>POLICY</b>	INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)		POLICY NUMBER		EFF DATE		<b>EMPLOYMENT STATUS CODE</b> <input type="checkbox"/> FULL TIME/REGULAR <input type="checkbox"/> PART TIME <input type="checkbox"/> PIECE WORKER <input type="checkbox"/> SEASONAL <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> APPRENTICE FULL TIME <input type="checkbox"/> APPRENTICE PART TIME		
			SELF INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO		EXP DATE				
<b>EMPLOYEE</b>	EMPLOYEE LAST NAME		PHONE INCL AREA CODE		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN				
	FIRST	MI	DEPARTMENT REGULARLY WORKED		OCCUPATION DESCRIPTION				
	ADDRESS LINE 1 & 2								
	CITY		STATE	ZIP	MARITAL STATUS <input type="checkbox"/> UNMARRIED, SINGLE, DIVORCED		<input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN NCCI CLASS CODE		
	SSN		DATE OF BIRTH	DATE OF HIRE					
<b>WAGE</b>	WAGE \$	PERIOD <input type="checkbox"/> WEEKLY <input type="checkbox"/> HOURLY <input type="checkbox"/> DAILY	NUMBER OF DAYS WORKED PER WEEK		SALARY CONTINUED IN LIEU OF COMPENSATION <input type="checkbox"/> YES <input type="checkbox"/> NO				
					FULL WAGES PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO				
<b>ACCIDENT/INJURY</b>	DATE OF INJURY		TIME OF INJURY <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> COULD NOT BE DETERMINED		TIME EMPLOYEE BEGAN WORK ON INJURY DATE <input type="checkbox"/> AM <input type="checkbox"/> 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 <input type="checkbox"/> WIDOW <input type="checkbox"/> FATHER                      _____ SISTER                      TOTAL # DEPENDENTS <input type="checkbox"/> WIDOWER                      _____ DAUGHTER                      _____ BROTHER <input type="checkbox"/> MOTHER                      _____ SON                      _____ HANDICAPPED CHILD						
	DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO								
ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)							COUNTY OF INJURY		
CITY				STATE	ZIP				
<b>TREATMENT</b>	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 <input type="checkbox"/> NO MEDICAL TREATMENT		<input type="checkbox"/> MINOR BY EMPLOYER <input type="checkbox"/> MINOR BY CLINIC/HOSPITAL		<input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> EMERGENCY CARE		<input type="checkbox"/> FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED		
<b>OTHER</b>	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		
				<b>TOTAL PAID</b>	

Date: \_\_\_\_\_ Name of Preparer and Title \_\_\_\_\_



**Tennessee Bureau of Workers' Compensation**  
**220 French Landing Drive, I-B**  
**Nashville, TN 37243-1002**  
**800-332-2667**

**FORM C-31**

**MEDICAL WAIVER AND CONSENT**

**This form is not required for injuries occurring on or after July 1, 2014**

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

I, \_\_\_\_\_, having filed a claim for workers' compensation benefits, do hereby authorize  
(Printed Patient Name)

\_\_\_\_\_ to furnish to my employer or my employer's  
(Name of Medical Provider)

representative, and/or the Bureau of Workers' Compensation any information or written material reasonably related to my work-related injury of \_\_\_\_\_ for which I am claiming compensation. I further authorize the release of  
(Date of Injury)

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

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

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth



Oficina de Compensación a Trabajadores de Tennessee  
Tennessee Bureau of Workers' Compensation  
220 French Landing Drive, I-B  
Nashville, TN 37243-1002  
800-332-2667

FORMULARIO C-31  
FORM C-31

**CONSENTIMIENTO Y EXENCIÓN MÉDICA**  
**MEDICAL WAIVER AND CONSENT**

**Este formulario no es requerido para lesiones que ocurrió el 1 de julio de 2014 o antes**  
**This form is not required for injuries occurring on or after July 1, 2014**

ESTE FORMULARIO DE AUTORIZACIÓN MÉDICA SOLAMENTE PERMITE QUE EL EMPLEADOR O LA OFICINA DE COMPENSACIÓN A TRABAJADORES OBTENGA INFORMACIÓN MÉDICA MEDIANTE COMUNICACIÓN ORAL O POR ESCRITO, INCLUYENDO PERO NO SE LÍMITA A GRÁFICOS, ARCHIVOS, REGISTROS, E INFORMES EN LA POSESIÓN DE UN PROVEEDOR MÉDICO AUTORIZADO POR EL EMPLEADOR SEGÚN T.C.A. § 50-6-204 Y UN PROVEEDOR MÉDICO QUE ES REEMBOLSADO POR EL EMPLEADOR PARA EL TRATAMIENTO DEL EMPLEADO.

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

Yo, \_\_\_\_\_, habiendo presentado una reclamación para beneficios de compensación a  
(Nombre del Paciente en letra de molde)  
trabajadores, por el presente autorizo a \_\_\_\_\_ a que proporcione a  
(Nombre de Proveedor Médico)  
mi empleador o al representante de mi empleador y/o a la Oficina de Compensación a Trabajadores cualquier información  
o material escrita asociada razonablemente a mi lesión con relación al trabajo de \_\_\_\_\_ para la cual  
(Fecha de Lesión)  
estoy reclamando compensación.

Adicionalmente, autorizo la divulgación de la misma información para mí o para mi abogado.

I, \_\_\_\_\_, having filed a claim for workers' compensation benefits, do hereby authorize  
(Printed Patient Name)  
\_\_\_\_\_ to furnish to my employer to furnish to my employer  
(Name of Medical Provider)

or my employer's representative, and/or the Bureau of Workers' Compensation any information or written material  
reasonably related to my work-related injury of \_\_\_\_\_ for which I am claiming compensation.  
(Date of Injury)

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

La autorización incluye, pero no se restringe al derecho de revisar y obtener copias de todos los registros, radiografías, informes de radiografías, gráficos médicos, recetas, diagnósticos, opiniones y cursos de tratamiento.

Una fotocopia de la autorización puede ser aceptada en lugar del original.

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

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

---

Firma del Paciente  
Patient Signature

Fecha  
Date

Fecha de Nacimiento  
Date of Birth

# Tennessee 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 Tennessee, when an employer has notice of an on-the-job injury, the employer shall provide the employee with a written list of designated providers from which the employee may select a physician or corporate medical provider.

This document contains a summary of the essential elements for the creation and maintenance of a designated provider list. Our staff is available to assist in this process. We can provide a list of qualified, reputable physicians and medical providers that are experienced in providing treatment of industrial injuries, familiar with workers' compensation, and strong advocates of a safe and expedient return to work.

## General Requirements

**Notice to Workers** - Notice of a panel, prior to injury, is not statutorily required. However, Form C-42 Employee's Choice of Physician should be provided by the employer to the employee within 5 business days from the date the employer has notice of an injury that would qualify for medical benefits. The employer must provide a panel of specialists within 3 business days of referral from the treating physician. The penalty for not providing a proper medical panel can be up to \$5,000 per violation.

**Included Physicians** - The panel must contain at least three reputable physicians or surgeons. The doctors placed on the panel must be from separate practices, if available in that community. Failure of the employer to provide the injured employee with a valid panel permits the injured worker to have their choice of any physician.

Under Tennessee law, the employer or insurance carrier is not required to offer a second panel of physicians or a second opinion. If asked, however, the insurer or employer MAY provide a second panel. An

employee may always seek a second opinion or obtain treatment with any physician at his/her own expense. However, only the restrictions of the authorized physician must be followed by the employer.

**Emergency Situation** - In an emergency situation, the employee shall be taken to any physician or medical facility that is able to provide the necessary care. When emergency care is no longer required, the above will apply.





**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 <b>Physician 4</b> 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 \_\_\_\_\_



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 Incident Report

This form should be filled out by the injured employee.

Name

Employer Name

Date of Incident

Time of incident

Time you began work on day of incident

Address of Incident

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 incident 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 incident occurred?

The above form is true and correct.

Signature

Date Completed



# Informe de Incidente del Empleado

A ser completado por el trabajador lesionado.



Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Hora en que usted empezó a trabajar el día del incidente

Dirección del Incidente

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 incidente? 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 incidente?

El informe anterior es verdadero y correcto.

Firma

Fecha En Que Se Completó El Formulario



# Supervisor's Report of Employment Incident

Employee Name

Employer Name

Date of Incident

Time of incident

Time the employee began work on day of incident

Did the employee report the incident immediately?

Address of Incident

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 incident occurred (including self)?

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



# Supervisor's Report of Employment Incident

Indicate working conditions present that led to incident (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 incident

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 de Incidente del Supervisor



Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Fecha en que se informó el incidente

¿Informó el empleado el incidente inmediatamente?

Dirección del Incidente

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 incidente (incluyendo él mismo)?

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



## Informe de Incidente del Supervisor

Indique las condiciones de trabajo presentes que conllevaron al incidente (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

Incidente 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 Incident



Employee Name

Witness' Name

Witness' Phone Number

Witness' Address

City, State

Zip

Offsite? (Y/N)

Date of Incident

Time of incident

Time you began work on day of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)

Did you witness the above-reported incident? 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 incident occurred?

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

The above form is true and correct.

Witness' Signature

Date Completed

# Informe de Incidente del Testigo



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 Incidente

Hora del incidente

Hora en que comenzó a trabajar el día del incidente

Dirección del incidente

Ciudad, Estado

Código Postal

Fuera del Lugar de Trabajo? (Si/ No)

¿Presenció el incidente? 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 incidente?

¿Había otros testigos presentes en el momento del incidente? 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 form to any pharmacy listed on the back side to speed processing of your approved work-related injury prescriptions (based on the guidelines established by your employer).

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

#### **Atencion Trabajador Lesionado:**

En su primera visita, entregue este formulario a cualquier farmacia que se encuentre en el reverso del boleto para acelerar el procesamiento de sus recetas aprobadas para lesiones relacionadas con el trabajo (según las reglas establecidas por su empleador).

¿Tiene preguntas o necesita ayuda para localizar una farmacia participante? Llame al centro de contacto para pacientes de MyMatrixx al 800.945.5951.

**ID#:** \_\_\_\_\_

Your SSN is your temporary ID.

**RxBIN#:** 003858

**PCN:** WC

**RxGroup #:** G3YA

**Date of Injury:** \_\_\_\_\_  
MM/DD/YYYY

**For Workers' Compensation Only**

### **Employee Information**

\_\_\_\_\_  
Full Name

\_\_\_\_\_  
Street Address or PO Box

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
ZIP

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Employer Name



### **To the Pharmacist:**

MyMatrixx 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, please call MyMatrixx at 888.786.9640.

#### **Processing Steps:**

1. Enter RxBin 003858
2. Enter PCN WC
3. Enter Rx Group Number G3YA
4. Enter 9-digit member ID (Patient SSN)
5. Enter Date of Injury

Visit [www.MyMatrixx.com](http://www.MyMatrixx.com) to locate a participating pharmacy near you!

AHF PHARMACY  
AHOLD CORPORATION  
ALBERTSONS  
ALIGNRX LLC  
AMERITA INC  
AURORA PHARMACY INC  
BIG Y FOODS INC  
BI-LO HOLDINGS LLC  
BROOKS/MAXI DRUG  
BROOKSHIRE BROTHERS LTD  
BROOKSHIRE GROCERY CO  
CARDINAL HEALTH  
CHEN NEIGHBORHOOD MEDICAL CENT  
COBORN'S INC.  
COSTCO WHOLESALE, INC  
CVS CORP  
DEDICATED US HOLDINGS LLC  
DISCOUNT DRUG MART  
ECKERD  
EPIC PHARMACY NETWORK  
ESSENTIA HEALTH  
EXPRESS RX  
FAIRVIEW PHARMACY SVCS  
FAMILY FARE, LLC

FOOD LION PHARMACY  
FRUTH PHARMACY  
GENOA HEALTHCARE LLC  
GIANT EAGLE PHARMACY  
GUARDIAN PHARMACY LLC  
HAC INC  
HANNAFORD BROS. CO.  
HARPS FOOD STORES INC  
HARTIG DRUG  
HEALTH MART ATLAS LLC  
H-E-B LP  
HENRY FORD HEALTH SYSTEM  
HOMETOWN PHARMACY INC  
HY-VEE FOOD STORES INC  
INGLES MARKETS  
INSTYMEDS CORP  
KPH HEALTHCARE SERVICES  
KS PHARM LLC  
K-VA-T FOOD STORES INC  
LEWIS DRUGS INC  
LONGS DRUG STORE  
MARC GLASSMAN INC  
MEDICAP PHARMACY, INC.  
MEDICINE SHOPPE  
MEIJER PHARMACY  
MERCY PHARMACY SERVICES

NCS HEALTHCARE  
NEIGHBORCARE PHARMACY  
OSBORN DRUGS INC  
PATIENT FIRST  
PHARMEDQUEST PHARMACY  
PHARMERICA, INC  
PMR US HOLDINGS  
PRESBYTERIAN MEDICAL  
PRESCRIBEIT RX  
PRICE CHOPPER PHARMACY  
PUBLIX SUPER MARKETS, INC  
RALEY'S  
RECEPT PHARMACY LP  
RITE AID CORPORATION  
SAFEWAY, INC.  
SAM'S CLUB  
SUPERVALU PHARMACIES, INC.  
TARGET  
THRIFTY WHITE STORES  
TOPS MARKETS LLC  
UNITED SUPERMARKETS INC  
WALGREENS  
WAL-MART  
WEGMANS FOOD MARKETS,  
WEIS MARKETS INC

Visit [www.MyMatrixx.com](http://www.MyMatrixx.com) to locate a participating pharmacy near you!



# \$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.