Sedgwick Claims Kit
North
Carolina

P.O. Box 14779 | Lexington, KY 40512 | Toll Free: 866-738-9201 | Fax: 859-280-3275

Dear Insured:

We would like to welcome you as a policyholder of Falls Lake National Insurance Company. Sedgwick is your Claims Administrator, and we are pleased to be able to provide you with workers' compensation claims handling services. Please follow the below instructions for filing a new claim and note the claim kit attachment.

Where do I report a claim?

> **Phone:** **855-728-5277 (855-7ATLAS7)**
> **Email:** 6200AtlasGeneralInsurance@sedgwickcms.com
> **Fax:** 866-383-3296

Where do I send my injured employee for medical treatment?

> **Website:** www.sedgwickproviders.com/AG

Sedgwick Claim Kit Attachments:

- Notice to Injured Workers and Employers (Form17) – ***MUST BE POSTED***
- Notice of Accident to Employer and Claim of Employee (Form 18)
- Employer Report of Employee Injury or Occupational Disease to the Industrial Commission (Form 19)
- Wage Statement (Form 22)
- Itemized Statement of Charges for Drugs (Form 25P)
- Itemized Statement of Charges for Travel (Form 25T)
- Authorization for Release and Use of Medical Information
- Express Scripts First Fill Temporary Pharmacy Card

Need a loss run?

> **Email us:** Lossruns@atlas.us.com

Have more questions?

Contact the Atlas Customer Care Team at Sedgwick - One of our friendly Client Services Associates will be happy to assist you.

> **Phone:** 866-738-9201
> **Email:** AtlasTeam@Sedgwickcms.com

We appreciate your business and believe that communication is critical for successful claims administration. We encourage you to contact us if you have any questions.

www.Atlas.us.com/claims

FORM 17 Revised 11/2014

N.C. WORKERS' COMPENSATION NOTICE TO INJURED WORKERS AND EMPLOYERS

All employees of this business, except specifically excluded executive officers, suffering work-related injuries may be entitled to Workers' Compensation benefits from the employer or its insurance carrier.

IF YOU HAVE A WORK-RELATED INJURY OR AN OCCUPATIONAL DISEASE

The Employee Should:

- Report the injury or occupational disease to the Employer immediately.
- Give written notice to the Employer within 30 days.
- File a claim with the Industrial Commission on a Form 18 immediately, but no later than 2 years from injury date or occupational disease. Give a copy to the Employer.
- If medical treatment and wage loss compensation are not promptly provided, call the insurance carrier/administrator or request a hearing before the Industrial Commission using a Form 33 Request for Hearing. Commission forms are available at website www.ic.nc.gov or by calling the Help Line.
- Your employer's workers' compensation insurance carrier is .
- The insurance policy number is _____ .
- Your employer's workers' compensation insurance policy is valid from _____ until _____ .

For assistance: Call the Industrial Commission HELP LINE—(800) 688-8349.

The Employer Should:

- Provide all necessary medical services to the Employee.
- Report the injury to the carrier/administrator and file a Form 19 Report of Injury within 5 days with the Industrial Commission, if the Employee misses more than 1 day from work or if cumulative medical costs exceed $2,000.00.
- Give a copy of your completed Form 19 to the Employee along with a copy of a blank Form 18 Notice of Accident.
- Ensure that compensation is promptly paid as required under the Workers' Compensation Act.

For assistance with Safety Education Training contact:
Director of Safety Education at (919) 807-2602 or safety@ic.nc.gov

NORTH CAROLINA INDUSTRIAL COMMISSION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335

Website: www.ic.nc.gov

TO EMPLOYER: THIS FORM MUST BE PROMINENTLY POSTED IF YOU HAVE WORKERS' COMPENSATION INSURANCE OR QUALIFY AS SELF-INSURED. (N.C. Gen. Stat. §97-93).

IC File # _____

Emp. Code # _____

Carrier Code # _____

Employer FEIN

NOTICE OF ACCIDENT TO EMPLOYER AND CLAIM OF EMPLOYEE, REPRESENTATIVE, OR DEPENDENT (G.S. §§97-22 THROUGH 24)

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employee's Name

Address

City State Zip

( ) -
Home Telephone

- -
Social Security Number

☐ M ☐ F
Sex

/ /
Date of Birth

( ) -
Employer's Name Telephone Number

Employer's Address City State Zip

Insurance Carrier Policy Number

Carrier's Address City State Zip

( ) - ( ) -
Carrier's Telephone Number Carrier's Fax Number

EMPLOYEE – This form must be filed with the Industrial Commission within two years of the date of injury or occupational disease or your claim may be barred. Notice shall be given to the employer immediately after the accident or as soon as practicable and within 30 days. (This form should also be used for occupational disease claims; however, for asbestosis, silicosis and byssinosis, Form 18B is to be used.)

Notice is hereby given, as required by law, that the above-named employee sustained an injury or contracted an occupational disease, described as follows: _____ (Time of Injury) on ____/ / (Date (required)) at _____ (City and County). Describe the injury or occupational disease, including the specific body part involved (e.g., right hand, left hand) _____

Describe how the injury or occupational disease occurred: _____

Occupation when injured: _____ Nature of employer's business: _____

Number of days out of work due to injury:

Medical treatment received? Yes No

Weekly wage: $ Number of hours worked per day: _____ Days worked per week: _____

NOTE: If employee is unable to sign this form, another may sign for him. This form should be typed or printed by hand in black ink, if possible. Employee should retain one signed copy of this notice, mail one signed copy to the Industrial Commission at the address below, and provide one signed copy to employer.

Signature of (Check One) Employee, Attorney, ☐ Representative, or Dependent

( ) -
Telephone Number

Address City State Zip

/ /
Date Completed

EMPLOYER: This notice is being sent to you in compliance with requirements of the North Carolina Workers' Compensation Act, in order that the medical services prescribed by the Act may be obtained; and, if disability extends beyond 7 days duration, or if death ensues, compensation may be paid according to law.

FOR IC USE ONLY

RESEARCHER: _____
CC: _____
EC: _____
DATA ENTRY: _____

FORM 18

MAIL TO:

NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

GENERAL INFORMATION ON THE FORM 18

1. What does a Form 18 do?

A Form 18 establishes a legal claim of injury on your behalf if filed within two years of the date of injury or occupational disease, and gives the required written notice to the employer if a copy is submitted to the employer within 30 days of the injury. The employer is required by law to file a Form 19 if the employee misses more than one day of work due to the injury or if the medical bills exceed $2,000.00. However, the employer's filing of a Form 19 does not satisfy the employee's obligation to file a claim. In order to ensure the employee's rights are protected, the employee must file a Form 18 even though the employer may be paying compensation or the Industrial Commission may have opened a file for the injury.

2. To whom should the Form 18 be sent?

The original Form 18 should be submitted to the Industrial Commission. The injured worker should keep one copy for his or her records and one copy should be submitted to the employer at the time of the injury.

3. What numbers do I write in the upper right corner?

You do not need to fill in the spaces on the upper right corner of the Form 18. If you know that your employer has already filed a report of injury, (Form 19) and you know what your I.C. (Industrial Commission), File Number is, you may write the number in the "I.C. File No." space. If you do not already have an I.C. File Number, the Industrial Commission will assign one upon receipt of the Form 18. The other three spaces, "Emp. Code No.," "Carrier Code No.," and "Employer FEIN" are for internal use only.

4. What if I do not know who my employer's insurance carrier is?

If you do not know who the employer's insurance carrier is you may either ask your employer for the information, call the Industrial Commission's Claims Administration Section at (800) 688-8349 then press "1" after the prompt, or simply leave the line blank.

5. When listing the number of days out of work, do I count partial days?

Yes, you include partial as well as whole calendar days not worked. However, the days do not need to be consecutive.

6. What happens after I file the Form 18?

The Industrial Commission will mail an acknowledgement letter to you after your Form 18 is processed. Processing time varies according to current workload. The Industrial Commission will mail a copy of the acknowledgement letter to the employer or its workers' compensation insurance carrier asking them to contact you and inform you if compensation will be paid to you voluntarily.

North Carolina Industrial Commission

IC File #_____

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

Emp. FEIN_____

Carrier FEIN

Carrier File #

To the Employer:
A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law.
This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

To the Employee:
This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed **Form 18** and mail it to Claims Administration, N.C. Industrial Commission, 4335 Mail Service Center, Raleigh, NC 27699-4335 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The use of this form is required under the provisions of the Workers' Compensation Act

Employee's Name | Employer's Name | ( ) - Telephone Number

Address | Employer's Address | City | State | Zip

City | State | Zip | Insurance Carrier | Policy Number

( ) - | - ( ) - | | |

Home Telephone | Work Telephone | Carrier's Address | City | State | Zip

- - | ☐ M ☐ F | / / | ( ) - | ( ) -

Social Security Number | Sex | Date of Birth | Carrier's Telephone Number | Fax Number

Employer	1.	Give nature of employer's business
Time And Place	2.	Location of plant where injury occurred
		County Department State if employer's premises
	3.	Date of injury / / 4. Day of week Hour of day : A.M. P.M.
	5.	Was employee paid for entire day 6. Date disability began / / A.M. P.M.
	.	Date you or the supervisor first knew of injury / / 8. Name of supervisor
Person Injured	9.	Occupation when injured
	10.	(a) Time employed by you (b) Wages per hour $
	11.	(a) No. hours worked per day (b) Wages per day $ (c) No. of days worked per week
		(d) Avg. weekly wages w/ overtime $ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. $ per
Cause And Nature Of Injury	12.	Describe fully how injury occurred and what employee was doing when injured:
		(Statement made without prejudice and without vouching for correctness of information)
	13.	List all injuries and specify body part involved (e.g. right hand or left hand):
	0.	Date & hour returned to work / / at : .M. 15. If so, at what wages $ per
	16.	At what occupation 17. Employee's salary continued in full?
	.	Was employee treated by a physician
Fatal Cases	19.	Has injured employee died 20. If so, give date of death (Submit Form 29) / /

Employer name _____ Date Completed ___/ /

Signed by _____ Official Title _____

OSHA 301 Information:

Case Number from Log:	Date Hired: / /	Time Employee began work on date of incident: : A.M. P.M.	If off-site medical treatment provided, answer entire next line.
Name of facility:		Address: Street/City/Zip/Telephone	ER visit? Yes No / Overnight stay? Yes No

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:

NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

FOR IC USE ONLY

RESEARCHER:_____
CC: _____
EC: _____
DATA ENTRY: _____

FORM 19

IMPORTANT INFORMATION FOR EMPLOYER

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This Form 19 must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident. Employer must also give employee a blank Form 18.

IMPORTANT INFORMATION FOR EMPLOYEE

Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON
ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS

Reporte de una Lesión (Reporting an Injury)

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un período de treinta (30) días a partir de la fecha de la lesión.

Cómo Presentar una Reclamación (Making a Claim)

Para ceriorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un período de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED PUEDE HABLAR AL (800) 688-8349

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA
EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN *[I.C. FILE NUMBER]* (SI LO SABE)
O SU NÚMERO DE SEGURO SOCIAL.

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:

NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

North Carolina Industrial Commission

IC File #_____

STATEMENT OF DAYS WORKED AND EARNINGS OF INJURED EMPLOYEE

Emp. Code #_____

Carrier Code # _____

Carrier File # _____

The Use Of This Form is Required Under The Provisions of The Workers' Compensation Act

Employer FEIN _____

Employee's Name

Address

City State Zip

Home Telephone Work Telephone

Social Security Number Sex Date of Birth

Employer's Name Telephone Number

Employer's Address City State Zip

Insurance Carrier Policy Number

Carrier's Address City State Zip

Carrier's Telephone Number Fax Number

Date of Injury: _____

Year: **200**	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Amount Earned	
Jan.																																	
Feb.																																	
Mar.																																	
Apr.																																	
May																																	
June																																	
July																																	
Aug.																																	
Sept.																																	
Oct.																																	
Nov.																																	
Dec.																																	

Total

Was this employee given free rent, lodging, or board or other allowances made in lieu of wages? _____
If so, state weekly value thereof: $ _____ .

SELF-INSURED EMPLOYER OR CARRIER MAIL

TO: NCIC - CLAIMS SECTION

RALEIGH, NC 27699-4335

TELEPHONE: (919) 807-2502

OMBUDSMAN: (800) 688-8349

FORM22

The undersigned employer of _____
(Name of Employee)

who alleges an injury on the _____ of _____,
(Day) (Month) (Year)

while in the employment of the undersigned, does hereby certify that the above is a true and correct statement of days worked and earnings of this employee during the 52 weeks immediately preceding the injury (or during the above weeks and parts thereof, if employed for less than 52 weeks) and while engaged in the occupation in which the employee was allegedly injured.

_____
Employer

By _____
Authorized Signature

/ /
_____
Date Signed

To Employer: Making a false statement for the purpose of denying workers' compensation benefits may result in a civil or criminal penalties.

INSTRUCTIONS

This form must be completed and filed with the Commission in all cases resulting in death unless maximum compensation rate is stipulated. It must also be filed in any other case if there is a disagreement about earnings or if the Commission requests it.

In preparing this form, place an X in the proper squares to indicate days paid in full. Days the employee is on paid vacation leave and/or paid sick leave should be marked with an X. Leave blank squares to indicate days not paid in full for any reason. Total earnings for each pay period should be placed in the proper column. If the employee's job or pay rate was changed during the reported period, this should be noted, with an indication as to the nature of the change.

The employer code number and the carrier code number, if any, must be inserted in the proper place at the upper right-hand corner of the form.

SELF-INSURED EMPLOYER OR CARRIER MAIL

TO: NCIC - CLAIMS SECTION

RALEIGH, NC 27699-4335

TELEPHONE: (919) 807-2502
OMBUDSMAN: (800) 688-8349

FORM22

North Carolina Industrial Commission

IC File # _____

ITEMIZED STATEMENT OF CHARGES FOR DRUGS

Emp. Code # _____

Carrier Code # _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act Employer FEIN __

Employee's Name

Address

City State Zip

( ) ( )
Home Telephone Work Telephone

U M U F / /
Social Security Number Sex Date of Birth

( )
Employer's Name Telephone Number

Employer's Address City State Zip

Insurance Carrier

Carrier's Address City State Zip

( ) ( )
Carrier's Telephone Number Fax Number

DATE	DRUG STORE	CITY	NAME OF DRUG & PRESCRIPTION NO.	PHYSICIAN	AMOUNT
				TOTAL	**$**

This is to certify that the drugs listed above were related to my workers' compensation injury. (Receipts must be furnished for carrier's file)

Employee signature

Carrier's approval

Reimburse employee
Yes U no U

Reimburse drug store
Yes U no U

EMPLOYEE: Mail your bill in duplicate promptly to employer and/or insurance carrier

EMPLOYER OR CARRIER/ADMINISTRATOR: DRUGS MAY BE REIMBURSED DIRECTLY TO THE EMPLOYEE OR DRUG STORE. IT IS NOT NECESSARY TO SUBMIT BILLS TO THE COMMISSION FOR APPROVAL. PAY AND RETAIN COPY IN CARRIER'S FILE.

FORM 25P

NCIC - MEDICAL BILLING SECTION
4337 MAIL SERVICE CENTER
RALEIGH, NC 27699-4337
MAIN TELEPHONE: (919) 807-2500 HELPLINE: (800) 688- 8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

North Carolina Industrial Commission

ITEMIZED STATEMENT OF CHARGES FOR TRAVEL

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

Employer FEIN _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

(_____) -
Employee's Name | Employer's Name | Telephone Number

Address | Employer's Address | City | State | Zip

City | State | Zip | Insurance Carrier

( ) - | ( ) -
Home Telephone | Work Telephone | Carrier's Address | City | State | Zip

( ) - | ( ) -
Carrier's Telephone Number | Fax Number

Employees are entitled to reimbursement of **$0.54** per mile for travel for medical treatment, provided they travel 20 miles or more roundtrip, starting January 1, 2016. Special consideration will be given to employees who are totally disabled. No reimbursement is allowed for trips to purchase medications or supplies unless medically necessary. These items must be purchased on visits to medical providers (G.S. §97-25).

DATE	NAME OF MEDICAL PROVIDER	CITY	TOTAL MILES ROUNDTRIP
/ /			
/ /			
/ /			
/ /			
/ /			

OTHER EXPENSES	If overnight stay is necessary, the following items will be approved as submitted. (Receipts must be furnished for carrier's file.)	Total motel expense ($45.00 per day):	Total Miles:
		Total meal expense ($6.00 Breakfast, $8.00 Lunch, and $14.00 Dinner):	**X [mileage rate]***
		Total parking & cab expense (actual charge):	Other expenses:
		Total for other expenses:	Total all expenses:

*Prior mileage rates are as follows: (a) **$0.575** for 2015; (b) **$0.56** for 2014; (c) **$0.565** for 2013; (d) **$0.555** for July 1, 2011 - December 31, 2012; (e) **$0.51** for January 1, 2011 - June 30, 2011; (f) **$0.50** for 2010; (g) **$0.55** for 2009; (h) **$0.585** for July 1, 2008 - December 31, 2008; (i) **$0.505** for January 1, 2008 - June 30, 2008; (j) **$0.485** for 2007; (k) **$0.445** for January 18, 2006 - December 31, 2006; and (l) **$0.31** for travel before January 18, 2006.

I hereby certify that I have incurred all expenses listed above as a result of my workers' compensation injury.

Employee signature

Carrier's approval

Employee:
Mail your bill in duplicate promptly to employer and/or insurance carrier

Employer or Carrier/Administrator:
Travel may be reimbursed directly to the employee. It is not necessary to submit bills to the Commission for approval. Pay and retain copy in carrier's file.

FORM 25T

FOR ASSISTANCE, CALL:
N.C. INDUSTRIAL COMMISSION
MAIN TELEPHONE: (919) 807-2500
WORKERS' COMPENSATION INFORMATION SPECIALISTS: (800) 688-8349

SPECIAL NOTE

There is a specific limitation to the release duration for this state, which is incorporated at number 3 on the release form.

Scroll to Next Page for Release Form

AUTHORIZATION FOR RELEASE AND USE OF MEDICAL INFORMATION

I authorize each of the parties identified below to use and disclose any and all of my individually identifiable medical or health information, as described below, for purposes of administering my claim or request for reasonable accommodation. I understand that the information about me that I authorize to be used or disclosed may be redisclosed in accordance with the terms of this Authorization by the recipient thereof and may no longer be protected by federal or state privacy laws or regulations.

I specifically authorize physicians, nurses and hospitals to communicate my individually identifiable medical or health information by any means, including written or telephonic communications or by direct interview, whether or not I am present during, or notified of, such communications, and I hereby authorize Sedgwick Claims Management Services, Inc. ("Sedgwick") to initiate and conduct such communications whether or not I am present or have received notice thereof.

1. **What Information is covered by this Authorization?** This authorization applies to all medical, health, psychological, and/or psychiatric information, records and reports, including information regarding pre-existing health or medical conditions or illnesses (a) that are in existence while this authorization is valid (see Item 3) and (b) that are related to any of the following: my request for reasonable accommodation; my workers' compensation claim; my claim for disability benefits; my claim for bodily injury; my claim for personal injury; my claim for FMLA or my claim for dental benefits.

   My claim or request for reasonable accommodation involves the following condition: _____

   My information to be disclosed may include, but is not limited to, medical or health history, chart notes, prescriptions, diagnostic test results, x-ray reports, and records received from other health care providers. If directly related to my claimed condition or illness, this information may include the following, **Please check yes or no and initial**:

HIV test results, HIV or AIDS information.	YES	NO	Initial here _____
Psychiatric information.	YES	NO	Initial here _____
Information related to drug or alcohol abuse.	YES	NO	Initial here _____

   The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

2. **Who may disclose and receive Information under this Authorization?**

   A. Any person or facility that attends, treats or examines me, including but not limited to _____

   _____(specific name, if needed) is to make this information available to Sedgwick or any of its agents, representatives or independent contractors; and

   . When relevant to my claim, Sedgwick may re-disclose (without my further authorization) any and all of my individually identifiable medical or health information (whether obtained pursuant to this authorization or otherwise from any person or entity) to any of the following, (a) Any person or facility that attends, treats or examines me; (b) Any person or facility that impacts determination of my claim or that coordinates my benefits; (c) My employer and its affiliates and their representatives, independent contractors and service providers that may receive any such information from my employer to the extent permitted by state or federal law; or (d) The Social Security Administration or a social security or vocational rehabilitation vendor. Sedgwick may use my information obtained pursuant to this authorization in any other claim matter that Sedgwick may administer or handle related to me.

3. **How Long this Authorization is Valid?** This authorization is valid during the duration of my claim(s) and any future related claims, unless a different period is required under applicable federal or state law. **(Release in connection with a claim for benefits for health insurance may not remain valid longer than the term of coverage of the policy; or for the duration of the claim for all other insurance claims)**.

4. **Revocation of this Authorization.** Unless otherwise provided by federal or state law, I understand that I may revoke this authorization at any time by notifying, in writing, Sedgwick at _____ of my revocation and that my revocation shall be effective upon Sedgwick receipt of my notice of revocation. I also understand that my revocation of this Authorization will not have any effect on any actions taken by Sedgwick before its receives my revocation.

5. **Processing of Claims.** I understand that this Authorization is generally necessary for the processing of my claim or request for reasonable accommodation. Failure to sign this Authorization may impair or impede the processing of my claim or request for reasonable accommodation.

6. **Refusal To Sign**. I further understand my health care providers will not condition my treatment, payment, enrollment or eligibility on my refusal to sign this Authorization.

I understand that I have the right to request and receive a copy of this authorization. I understand that I have the right to inspect the disclosed information at any time. A photocopy of this authorization shall be valid and is to be accepted with the same effect as the original.

Signature of Patient or Patient's Representative	Patient's Address
Printed Name of Patient or Patient's Representative	Patient's Social Security Number
Representative's Relationship to Patient, if applicable	First Day Absent
Date Signed	Date of Birth

AUTORIZACIÓN PARA USO Y DIVULGACIÓN DE INFORMACIÓN MÉDICA

Yo, autorizo a cada una de las partes identificadas a continuación, para usar y divulgar cualquier y toda información médica y de salud inidentificable individualmente como mía, como se describe más adelante, para propósitos de administración de mi solicitud o petición para un acomodo razonable. Entiendo que la información sobre mí, que yo autorizo para uso y divulgación, puede estar sujeta a divulgación posterior, de acuerdo con los términos de esta Autorización, por parte del destinatario de ésta y que es posible que ya no esté protegida por las leyes y regulaciones federales o del estado sobre privacidad.

Autorizo, específicamente, a médicos, enfermeras y hospitales para comunicar la información de salud o médica identificable individualmente como mía, a través de cualquier medio, incluidas comunicaciones escritas o telefónicas, o por entrevista directa, sea que este presente o se me haya notificado o no, de dichas comunicaciones, y por la presente, autorizo a Sedgwick Claims Management Services, Inc. ("Sedgwick") para iniciar y realizar dichas comunicaciones, sea que este presente o haya recibido notificación de esto o no.

1. **¿Qué información está incluida en esta Autorización?** Esta autorización se aplica a toda la información, registros e informes médicos, de salud, sicológicos y/o psiquiátricos, incluida información sobre condiciones o enfermedades médicas o de salud pre-existentes (a) que estén en existencia durante la validez de esta autorización (ver Punto 3) y (b) que estén relacionadas con cualquiera de las siguientes solicitudes: mi solicitud de acomodo razonable, mi solicitud de compensación del trabajador; mi solicitud de prestación por invalidez, mi solicitud por lesión corporal, mi solicitud por accidentes personales, mi solicitud de FMLA o mi solicitud de prestaciones dentales.

   Mi solicitud o petición para acomodo razonable involucra las siguientes condiciones:

   Mi información, que será divulgada, puede incluir, pero no se limita a, historia médica o de salud registros médicos, prescripciones, resultados de evaluaciones de diagnóstico, informes de rayos X y registros recibidos de otros prestadores de salud. Esta información puede incluir lo siguiente, si está directamente relacionada con las condiciones o enfermedades demandadas. **Por favor, marque sí o no e inicial**:

resultados de pruebas de VIH, información sobre VIH o SIDA	SÍ	NO	Inicial aquí _____
Información siquiátrica.	SÍ ☐	NO ☐	Inicial aquí _____
Información relacionada con abuso de drogas o alcohol.	SÍ ☐	NO ☐	Inicial aquí _____

   La Ley contra la discriminación de información genética de 2008 (GINA, por sus siglas en inglés) prohíbe a los empleadores y otras entidades que abarca el Título II de la GINA solicitar o requerir información genética de un individuo o miembro de la familia del individuo, excepto en los casos específicamente permitidos por esta ley. Para cumplir con esta ley, le solicitamos no brindar ninguna información genética cuando responda a esta solicitud de información médica. "Información genética", como lo define la GINA, incluye la historia médica de la familia de un individuo, los resultados de pruebas genéticas del individuo o la de un miembro de su familia, el hecho de que un individuo o un miembro de la familia del individuo buscó o recibió servicio genéticos e información genética de un feto que el individuo o un miembro de la familia del individuo está gestando o un embrión en el vientre legalmente en el individuo o un miembro de la familia del individuo que recibe servicios reproductivos de asistencia.

2. **¿Quién puede divulgar y recibir información bajo esta Autorización?**

   A. Cualquier persona o entidad que me atienda, trate o examine, incluida, pero no limitada a _____ (nombre específico, si es necesario) para poner esta información _____ a disposición de Sedgwick o cualquiera de sus funcionarios, representantes o contratistas independientes; y

   A. Cuando sea pertinente a mi solicitud, Sedgwick puede divulgar posteriormente (sin autorización ulterior) cualquier o toda información médica o de salud identificada individualmente como mía (fuese obtenida de acuerdo con esta autorización o, de lo contrario, de otra persona o entidad) a cualquiera de los siguientes: (a) cualquier persona o institución que me atienda, trate o examine; (b) cualquier persona o institución que influya en la determinación de mi solicitud o que coordine mis beneficios; (c) mi empleador y sus afiliados y sus representantes, contratistas independientes y prestadores de servicios que puedan recibir tal información de mi empleador hasta al grado que permite la ley federal o estatal, o (d) la Dirección del Seguro Social o el proveedor de seguro social o rehabilitación vocacional. Sedgwick puede usar mi información, obtenida de acuerdo con esta autorización, en cualquier otra materia de solicitud que Sedgwick pueda administrar o manejar en relación a mí.

3. **¿Por cuánto tiempo es válida esta Autorización?** Esta autorización es válida por el período de duración de mi(s) petición(es) y de cualquier petición relacionada futura; a menos que se requiera un período diferente de acuerdo con la ley federal o estatal correspondiente.

4. **Revocación de esta Autorización.** A menos que la ley federal o estatal establezca otra cosa, entiendo que puedo revocar esta autorización en cualquier momento al notificar, por escrito, a Sedgwick a _____ de mi revocación y que ésta entrará en efecto una

vez que Sedgwick haya recibido mi notificación de revocación. También entiendo que mi revocación de esta Autorización no tendrá ningún efecto sobre las acciones tomadas por Sedgwick antes del recibo de mi revocación.

7. **Procesamiento de una Solicitud.** Entiendo que esta Autorización, generalmente, es necesaria para el procesamiento de una solicitud o petición de acomodo razonable. El no firmar esta autorización puede perjudicar o impedir el procesamiento de mi solicitud o petición de acomodo razonable.

8. **Denegación de Firma** Además, entiendo que mis prestadores de atención médica no condicionarán mi tratamiento, pago, inscripción o elegibilidad, en caso de negarme a firmar esta Autorización.

Entiendo que tengo derecho a solicitar y recibir una copia de esta autorización. Entiendo que tengo derecho de inspeccionar la información divulgada en cualquier momento. Una fotocopia de esta autorización será válida y aceptada con el mismo efecto que el original.

Firma del Paciente o Su Representante	Dirección del Paciente:
Nombre del Paciente o Su Representante	Número del Seguro Social del Paciente
Parentesco del Representante con el Paciente, si corresponde	Primer Día Ausente
Día de Firma	Fecha de Nacimiento

Workers' Compensation Temporary Prescription ID Card

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 1-866-590-5882.

Atencion Trabajador Lesionado:

Este form ulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 1-866-590-5882.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at 1-866-590-5882.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control A4

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

Group #: GJC6200

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

_____

sedgwick

EXPRESS SCRIPTS®

Participating Retail Network Pharmacies

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
Dom inicks
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
Pathm ark
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
Wal-Mart
Wegmans
Weis
Winn Dixie

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