Sedgwick Claims Kit
Nevada

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 Southern 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) OR;**
- **Email:** 6200AtlasGeneralInsurance@sedgwickcms.com OR:
- **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 Employees (D-1) – *MUST BE POSTED*
- Employer's First Report of Injury Form (C-3)
- Notice of Injury or Occupational Disease (C-1) – *MUST BE PROVIDED TO INJURED EMPLOYEES*
- Employee's Claim for compensation/Report of Initial Treatment (C-4) - *MUST BE PROVIDED TO INJURED EMPLOYEES*
- Employee Rights (D-2) - *MUST BE PROVIDED TO INJURED EMPLOYEES*
- Choice of Physicians form (D-52)
- Mileage form (D-26(1))
- Authorization for Release and Use of Medical Information (D-36)
- Atlas General First Fill Temporary Pharmacy Card
- Atlas General 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

State of Nevada

DEPARTMENT OF BUSINESS & INDUSTRY

DIVISION OF INDUSTRIAL RELATIONS

Workers' Compensation Section

A T T E N T I O N

Brief Description of Your Rights and Benefits If You Are Injured on the Job or have an Occupational Disease

Notice of Injury or Occupational Disease (Incident Report Form C-1) If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the forms.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation and your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer,** by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a hearing officer decision, you may request that NAIW represent you without charge at an Appeals Officer hearing. NAIW is an independent state agency and is not affiliated with any insurer. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street, Suite 208, Carson City, NV 89701, (775) 684-7555, or 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830.

To File a Complaint with the Division: If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775)684-7270, or 1301 North Green Valley Parkway, Suite 200, Henderson, Nevada 89074, telephone (702) 486-9080.

For Assistance with Workers' Compensation Issues: You may contact the Office of the Governor Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1-888-333-1597, Web site: http:/govcha.state.nv.us, E-mail cha@govcha.state.nv.us

The information in this publication is derived from Chapters 616A and 617 of the Nevada Revised Statutes and is provided for informational purposes only. If you have any questions, regarding your injury or workers' compensation claim, please call the following:

Insurer/Administrator: ______________________ Contact Person: ______________________

Address: ______________________ Telephone Number: ______________________

City State Zip

MCO/Health Care Provider: ______________________ Contact Person: ______________________

Address: ______________________ Telephone Number: ______________________

City State Zip

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C-4 FORM

Please Type or Print

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
Office Mail Address	Location . . . If different from mailing address	Telephone	
City State Zip	**INSURER**	**THIRD-PARTY ADMINISTRATOR**	

EMPLOYEE

First Name M.I. Last Name	Social Security	Birthdate	Age	Primary Language Spoken
Home Address (Number and Street)	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
City State Zip	Was the employee paid for the day of injury? (If applicable) ☐ Yes ☐ No	How long has this person been employed by you in Nevada?		
In which state was employee hired?	Employee's occupation (job title) when hired or disabled	Department in which regularly employed:		
Telephone	Is the injured employee a corporate officer? ☐ Yes ☐ No . . . sole proprietor? ☐ Yes ☐ No . . . partner? ☐ Yes ☐ No	Was employee in your employ when injured or disabled by occupational disease (O/D)? ☐ Yes ☐ No		

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
Address or location of accident (Also provide city, county, state) (if applicable)	Accident on employer's premises? (if applicable) ☐ Yes ☐ No		
What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)			
How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.			

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable)		Witness	Was there more than one person injured in this accident? (if applicable) ☐ Yes ☐ No
Part of body injured or affected	If fatal, give date of death	Witness	
Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.)		Witness	
		Did employee return to next scheduled shift after accident? (if applicable) ☐ Yes ☐ No	Will you have light duty work available if necessary? ☐ Yes ☐ No
If validity of claim is doubted, state reason		Location of Initial Treatment	
Treating physician/chiropractor name		Emergency Room ☐ Yes ☐ No	Hospitalized ☐ Yes ☐ No
IMPORTANT	How many days per week does employee work?	From ☐ am ☐ pm To ☐ am ☐ pm	Last day wages were earned
Scheduled days off S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ Rotating ☐		Are you paying injured or disabled employee's wages during disability? ☐ Yes ☐ No	

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost
Was the employee hired to work 40 hours per week? ☐ Yes ☐ No	If not, for how many hours a week was the employee hired?	Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☐ No ☐ Do not know	

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on: ☐ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI	Emloyee is paid: ☐ WEEKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY	On the date of injury or disability the employee's wage was: $ per ☐ Hr ☐ Day ☐ Wk ☐ Mo

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.	Employer's Signature and Title	Date

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No.	Class Code
Claims Examiner's Signature	Date	Status Clerk	Date

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report)

Pursuant to NRS 616C.015

Name of Employer ______________________________

Name of Employee	Social Security Number	Telephone Number

Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)

What is the nature of the injury or occupational disease?	List any body parts involved:

Briefly describe accident or circumstances of occupational disease:
(Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)

Names of witnesses:

Did the employee leave work because of the injury or occupational disease? _____ YES _____ NO	If yes, when (date and time)?	Has the employee returned to work? ____ YES ____ NO	If yes, when (date and time)?
Was first aid provided? ____ YES ____ NO	If yes, by whom?	Name and address of treating physician, if applicable or known	
Did the accident happen in the normal course of work? (if applicable) ____ YES ____ NO			
Was anyone else involved? ____ YES ____ NO	Names of others involved		

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

______________________________ ______________________________

Supervisor's Signature Date Signature of Injured or Disabled Employee Date

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

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Employee should sign, date and retain a copy.
Original to Employer, Copy to Employee

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM – PROVIDE ALL INFORMATION REQUESTED

First Name M.I. Last Name	Birthdate	Sex ☐ M ☐ F	Claim Number (Insurer's Use Only)
Home Address	Age / Height	Weight	Social Security Number
City State Zip		Telephone	
Mailing Address City State Zip			Primary Language Spoken
INSURER	**THIRD-PARTY ADMINISTRATOR**	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred	
Employer's Name/Company Name			Telephone
Office Mail Address (Number and Street)			

Date of Injury (if applicable)	Hours Injury (if applicable) am pm	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported

Address or Location of Accident (if applicable)

What were you doing at the time of the accident? (if applicable)

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)

If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?

Witnesses to the Accident (if applicable)

Nature of Injury or Occupational Disease	Part(s) of Body Injured or Affected

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER, OR OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Date Place Employee's Signature

THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Place Name of Facility

Date / Hour	Diagnosis and Description of Injury or Occupational Disease	Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? ☐ No ☐ Yes (if yes, please explain)

Treatment:

X-Ray Findings:

From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? ☐ Yes ☐ No

Is additional medical care by a physician indicated? ☐ Yes ☐ No

Have you advised the patient to remain off work five days or more?

☐ Yes Indicate dates: from ____________ to __________________

☐ No If no, is the injured employee capable of: ☐ full duty ☐ modified duty

If modified duty, specify any limitations/restrictions: ______________________

____

____

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ No (Explain if yes)

Date	Print Doctor's Name	I certify that the employer's copy of this form was mailed to the employer on:
Address		INSURER'S USE ONLY
City State Zip	Provider's Tax I.D. Number / Telephone	
Doctor's Signature	Degree	

BRIEF DESCRIPTION OF RIGHTS AND BENEFITS
(Pursuant to NRS 616C.050)

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State of Nevada
Department of Business & Industry

Division of Industrial Relations

Workers' Compensation Section

ALTERNATIVE CHOICE OF PHYSICIAN or CHIROPRACTOR (NRS 616C.090)

A list of the Panel of Treating Physicians or Chiropractors, or those health care providers, with whom your insurer has contracted, can be obtained from your insurer or third-party administrator upon written request. Your insurer or third-party administrator has 3 working days to provide you the list pursuant to NAC 616C.030.

If within the **first 90 days after the date of injury**, you are not satisfied with the **first** treating physician or chiropractor and

> Your insurer **has entered** into a contract with a managed care organization or with health care providers; you must select an alternative physician or chiropractor according to the terms of the contract. This selection may be made without the prior approval of the insurer. If after choosing your physician or chiropractor, you move to a county not serviced by the contracted managed care organization or health care providers and the insurer deems it impractical for you to continue treating with the physician or chiropractor, you must choose a treating physician or chiropractor who has agreed to the to the terms of the contract unless the insurer authorizes you to choose another physician or chiropractor;

or

> Your insurer **has not entered** into a contract with an organization for managed care, or with health care providers, you may select an alternative physician or chiropractor from the Panel of Treating Physicians and Chiropractors.

NOTICE: Any further changes in your treating physician or chiropractor must be in writing and approved by the insurer. If, at any time, you are dissatisfied with a physician or chiropractor selected by yourself, the insurer, managed care organization, or health care provider, a change may be made by submitting a written request to the insurer indicating the name of the alternate physician or chiropractor. The insurer shall approve or deny this request within ten (10) days after receipt of the written request or it shall be deemed approved. You will receive written notification if the insurer denies this request which will include the reason for the denial and appeal rights.

APPLICATION FOR REIMBURSEMENT OF CLAIM RELATED TRAVEL EXPENSES

(Pursuant to NAC 616C.150)

Please type or print and provide all the information requested. Keep and be prepared to provide, if requested, any receipts relating to your reimbursement request.

Name (Last, First, Middle Initial)			Claim Number
Present Address (P.O. Box, Apt. No., Street)			Social Security Number
City	State	Zip	Date of Injury
Residence at time of injury:			(For Insurer's Use Only) [__] Approved ______________ [__] Disapproved Initials & Date

REPORT TRAVEL WEEKLY. See reverse side of this form for the regulations under which you may be reimbursed for claim related travel. **Be aware that any misrepresentation may be considered fraud and is in violation of Nevada law.**

Date	Beginning Point of Travel Address	Destination Name/Address	Enter Travel Time	Leave Travel Time	Daily Expense Reimbursement				Miles One Way	Mileage Allowed (For Insurers Use Only)
					Meals			Lodging		
					B	L	D			
								TOTAL MILES:		

Total of ____________ Miles X 2 @ $ ________ . ____ per Mile = ______

I hereby certify that the record provided above is correct to the best of my knowledge and that all of the mileage for which I am requesting reimbursement is related to or is for treatment authorized under Nevada Revised Statute (NRS) 616A to 616D, inclusive or chapter 617 of NRS. **I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits, and may subject me to criminal and civil penalties.** I certify under penalty of perjury that the above information is correct to the best of my knowledge.

______________________________________ ______________________________

Injured Employee's Signature Date

Reimbursement for Costs of Transportation and Meals

Nevada Administrative Code (NAC) 616C.150 Eligibility and computation.

1. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from:

(a) His residence to the place where he receives medical care; or

(b) His place of employment to the place where he receives medical care if the care is required during his normal working hours.

2. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from his residence or place of employment to a place of hearing designated by the insurer or the department of administration if the hearing concerns an appeal by the employer or insurer from a decision in favor of the injured employee and the decision is upheld on appeal.

3. An injured employee who does not qualify for reimbursement under paragraph (a) or (b) of subsection 1 but is required to travel a total of 40 miles or more in any one week for medical care or for attendance at the system's rehabilitation center is entitled to be reimbursed for the cost of his transportation.

4. Except as otherwise provided in subsection 6, reimbursement for the cost of transportation must be computed at a rate equal to:

(a) The mileage allowance for state employees who use their personal vehicles for the convenience of the state; or

(b) The expense actually incurred by the injured employee for transportation, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

5. Except as otherwise provided in subsection 6, if an injured employee must travel before 7:00 a.m. or between 11:30 a.m. and 1:30 p.m. or cannot return to his home or place of employment until after 7:00 p.m., or any combination thereof, reimbursement for meals required to be purchased must be computed at a rate equal to:

(a) That allowed for state employees; or

(b) The expense actually incurred by the injured employee for meals, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

6. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for his expenses of travel if he is required to travel 50 miles or more, one way, from his residence or place of employment and is required to remain away from his residence or place of employment overnight. Reimbursement must be computed at a rate equal to:

(a) The per diem allowance authorized for state employees; or

(b) The expenses actually incurred by the injured employee, whichever is less.

7. A claim for reimbursement of expenses governed by this section may be disallowed unless it is submitted to the insurer or employer within 60 days after the expenses are incurred.

NAC 616C.153 Reimbursement for air fare. With the prior approval of the insurer or those employers who have elected to provide accident benefits, an injured employee may be reimbursed for air fare where the time, distance, convenience or cost justifies his travel by air.

NAC 616C.156 Limitations on reimbursements.

1. Unless otherwise directed or approved by the insurer, or the injured employee's treating physician or chiropractor, an injured employee who chooses to obtain his medical services at a more distant place although adequate medical care is available at a closer place may be reimbursed under NAC 616C.150 only for mileage to the closer place.

2. If a person moves outside this state or to a new location within this state for his own convenience after becoming an injured employee, the maximum mileage for one direction for which he may be reimbursed is the mileage allowable before the move or 40 miles, whichever is greater.

3. No reimbursement will be allowed for a person traveling with an injured employee unless there is a medical necessity that precludes the injured employee from traveling alone. The medical necessity must be substantiated in writing by the injured employee's treating physician or chiropractor.

Notice

An injured employee or any other person who knowingly makes a false statement or representation or knowingly conceals a material fact in order to obtain or attempt to obtain any benefit may be subject to both civil penalties and criminal prosecution. If convicted, a person forfeits all rights to workers' compensation benefits and is liable for reasonable investigation costs of the insurer and attorney general's office, court costs, and restitution for payment or benefits fraudulently obtained. If the amount of the benefit or payment is less than $250, the penalty is a misdemeanor which may result in county jail time not to exceed six months and a fine up to $1,000. If the amount of the benefit or payment is $250 or more, the penalty is a category D felony which may result in imprisonment in the state prison for at least 1 year and not more than 4 years and a fine up to $5,000. Insurance fraud includes, but is not limited to: 1) requesting temporary total disability compensation or rehabilitation maintenance compensation while gainfully employed; 2) making false statements about potential employer contacts, mileage or compensation, 3) misrepresenting facts concerning an industrial accident, injury or illness to others such as an employer, insurer, physician or chiropractor, vocational rehabilitation counselor, and 4) filing an invalid claim in order to obtain controlled substances.

If the employee is so severely injured that he is unable to complete this form, a friend, member of the family, labor representative, or other agent may complete and sign for the injured employee.

Request for Additional Medical Information And Medical Release

(Pursuant to NRS 616C.177 & 616C.490(4))

Injured Employee's Name: ______________________________

Claim Number: ____________________ Social Security Number: ____________________

Injured Employee's Address: ______________________________

Injury/Occupational Disease Date: ____________________ Date this Notice Printed: ____________________

Insurer's Name: ____________________ Employer: ____________________

Insurer's Address: ____________________ Employer's Address: ____________________

____________________ ____________________

Please provide the information requested below, sign and date the form, and return it to your insurer. Your signature on this form also acts as a release to acquire information affecting your claim from other entities. This renews the release you signed on your C-4 form at the time your claim was submitted to your insurer. Failure to fully complete and return this form to your claims agent in a timely manner could affect your benefits or delay the resolution of your claim.

Prior History Information

Please check the appropriate box below and provide the information requested.

☐ **I have no prior conditions, injuries or disabilities of which I am aware, that might affect the disposition of the claim referenced above. (If you checked this box, no further information is needed at this point)**

☐ **I have a prior condition, injury or disability that could affect the disposition of the claim referenced above. This can include birth defects, prior surgeries, injuries, etc., whether work related or not. (If you checked this box, indicating a pre-existing condition, please explain in detail in the space below. Please attach additional sheets of paper to this form if necessary to fully explain the condition)**

____

____

____

I certify that the above is true and correct to the best of my knowledge and that I have provided this information in order to obtain the benefits of Nevada's industrial insurance and occupational diseases acts (NRS 616A to 616D, inclusive or chapter 617 of NRS). I hereby authorize any physician, chiropractor, surgeon, practitioner, or other person, any hospital, including veterans administration or governmental hospital, any medical service organization, any insurance company, or other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to diagnosis, treatment and/or counseling for aids, psychological conditions, alcohol or controlled substances, for which I must give specific authorization. A photostat of this authorization shall be as valid as the original.

____________________ ____________________

Signature Date

First Fill
Temporary Pharmacy Card

Making it easy to get your workers' compensation prescriptions filled.

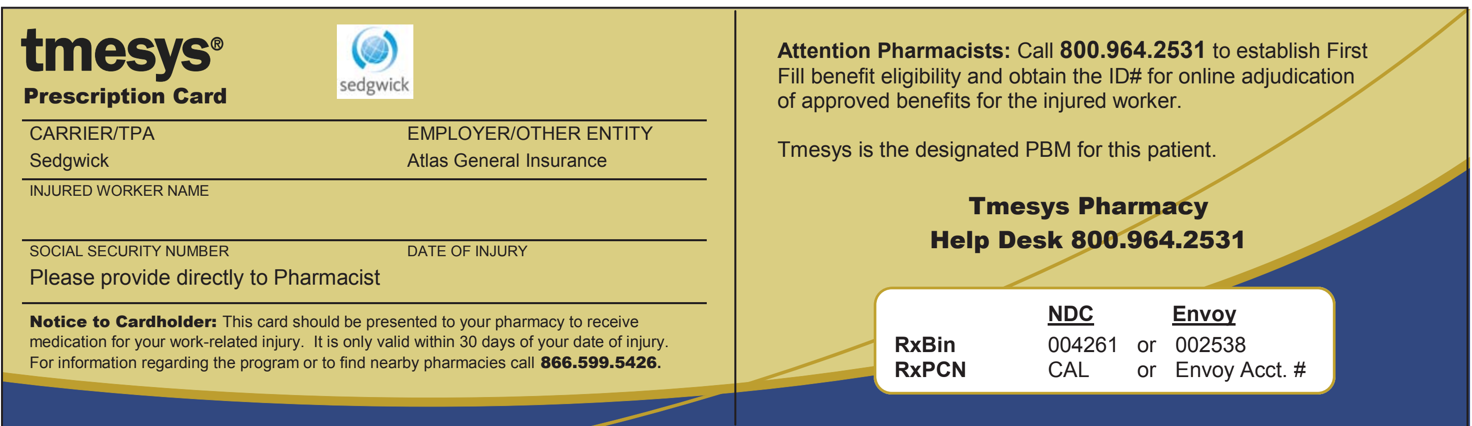
Just follow these easy steps...

Employer:

Print this page immediately upon receiving notice of injury, fill in the information below and give it to your employee.

Injured Employee:

1. If you need a prescription filled for a work-related injury or illness, go to a Tmesys network pharmacy.
2. Give this page to the pharmacist.
3. The pharmacist will fill your prescription at no cost.



tmesys®
Prescription Card

CARRIER/TPA
Sedgwick

EMPLOYER/OTHER ENTITY
Atlas General Insurance

INJURED WORKER NAME

SOCIAL SECURITY NUMBER
Please provide directly to Pharmacist

DATE OF INJURY

Notice to Cardholder: This card should be presented to your pharmacy to receive medication for your work-related injury. It is only valid within 30 days of your date of injury. For information regarding the program or to find nearby pharmacies call **866.599.5426**.

Attention Pharmacists: Call **800.964.2531** to establish First Fill benefit eligibility and obtain the ID# for online adjudication of approved benefits for the injured worker.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy
Help Desk 800.964.2531

	NDC		Envoy
RxBin	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #

(To create a card for your wallet, cut along outer line and fold in half.)

Pharmacist:

1. Call the Tmesys Pharmacy Help Desk at **800.964.2531.**
2. Provide the information listed above.
3. The Help Desk will provide an ID number for adjudication.

Finding a Network Pharmacy

Use one of these easy methods to find a network pharmacy:

- Visit one of the following pharmacy chains:

Walgreens	**Walmart**	**Duane Reade**	**Publix**
Rite Aid	**CVS**	**Kroger**	**Safeway**

- Use our pharmacy locator online: **www.pmsionline.com/pharmacy-center**.
- Call us: **866.599.5426**

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tmesys®

Tmesys Retail Pharmacy Network*

More than 60,000 pharmacies, including large chains and many neighborhood independent pharmacies, meaning that your prescription can be filled at most pharmacies nationwide.

Accredo Health Group
Anchor Pharmacy
Arrow Prescription Center
Aurora Pharmacy
Baker's Pharmacy
Bartell Drugs
Bashas' United Drug
Bel Air Pharmacy
Big Y Pharmacy
Biggs Pharmacy
Bi-Lo
Bi-Mart
Bioscrip Pharmacy
BJ's Pharmacy
Brookshire's Pharmacy
Bruno's Pharmacy
Buehler's Pharmacy
Caremark Pharmacy
Carle Rx Express
Carrs Quality Center
City Market Pharmacy
Clinic Pharmacy
Coborn's/Cash Wise
Concord Drugs
Costco Pharmacy
Cub Pharmacy
CVS Pharmacy
D&W Pharmacy
Dahl's Pharmacy
Dierbergs
Dillon Pharmacy
Discount Drug Mart
Doc's Drug
Dominick's Finer Foods
Drug Emporium
Drug Mart
Drug Town
Drug Warehouse
Drugs For Less
E. W. James Pharmacy
Eagle Pharmacy
Eaton Apothecary
Econofoods Pharmacy
Edwards Pharmacy
Fagen Pharmacy
Family Drug Store
Family Fare Pharmacy
Family Pharmacy
Familymeds Pharmacy
Farm Fresh Pharmacy
Farmer Jack Pharmacy
Food 4 Less Pharmacy
Food City Pharmacy
Food Lion Pharmacy
Food Town Pharmacy
Food World Pharmacy
Fred Meyer Pharmacy
Fred's Pharmacy
Fruth Pharmacy
Fry's Pharmacy
Gemmel Pharmacy
Gentiva Health Services
Genuardi's Pharmacy
Gerbes Pharmacy
Giant Eagle Pharmacy
Giant Pharmacy
Glen's Pharmacy
Good Day Pharmacy
Grand Union Pharmacy
Gristedes Pharmacy
H-E-B Pharmacy
Haggen Foods
Hannaford
Happy Harry's
Harmons Pharmacy
Harps Pharmacy
Harris Teeter
Hartig Drug
Harvest Foods Pharmacy
Harveys Supermarket Pharmacy
Hen House Pharmacy
Hi-School Pharmacy
Homeland Pharmacy
Hometown Pharmacy
Hy-Vee Pharmacy
Ingles Pharmacy
Kmart Pharmacy
Kerr Drug
King Kullen Pharmacy
King Soopers Pharmacy
Kings Pharmacy
Kinney Drugs
Klingensmith's
Knight Drugs
Kohl's Pharmacy
Kohll's Pharmacy
Kopp Drug
Kroger Pharmacy
Lewis Pharmacy
Lifechek Drug
Longs Drug
Louis and Clark
Lowes Marketplace
Marc's Pharmacy
Marsh Drugs
Martin's Pharmacy
May's Drug Store
Med-Fast Pharmacy
Medical Arts Pharmacy
Medicap Pharmacy
Medicine Shoppe Pharmacy (various)
Med-X Drug
Meijer Pharmacy
Minyard Pharmacy
Morton Pharmacy
Mr. Discount Drugs
Navarro Discount Pharmacies
NeighborCare Pharmacy
No Frills Pharmacy
Network Pharmacy
Owens Pharmacy
P&C Food & Pharmacy
Pamida Pharmacy
Park Nicollet Pharmacy
Pathmark Pharmacy
Pavilions Pharmacy
PharmaCare Pharmacy
Pharmacy Express
Pharmacy Plus
Pick 'N Save Pharmacy
Piggly Wiggly
PrairieStone Pharmacy
Price Chopper Pharmacy
Price Cutter Pharmacy
Publix Pharmacy
Q Pharmacy
QFC Pharmacy
Quality Markets Pharmacy
QuickChek Pharmacy
QVL Pharmacy
Rainbow Pharmacy
Raley's Drug Center
Ralphs Pharmacy
Randalls Pharmacy
Reasors Pharmacy
Rite Aid Pharmacy
Ritzman Natural Health
Rosauers Pharmacy
RXD Pharmacy
Sack 'n Save Pharmacy
Safeway Pharmacy
Sam's Pharmacy
Save Mart Pharmacy
Save-Rite Pharmacy
Schnucks Pharmacy
Scolaris Pharmacy
Sedanos Pharmacy & Discount
Shaw's Pharmacy
Shaws/Osco Pharmacy
Shop 'n Save Pharmacy
Shopko Pharmacy
Shoppers Pharmacy
ShopRite Pharmacy
Snyder Drug Emporium
Southern Family Market
Star Pharmacy
Stop & Shop Pharmacy
Sunscript Pharmacy
Super 1 Pharmacy
Super D
Super G
Super Foodmart Pharmacy
Super Fresh Pharmacy
Super Rx Pharmacy
Sweetbay
The Pharm
Thriftway Drugs
Thrifty White Drug
Times Pharmacy
Tom Thumb Pharmacy
Tops Pharmacy
U-Save Pharmacy
Ukrops Pharmacy
United Pharmacy
USA Drug
Vix Pharmacy
Vons Pharmacy
VG's Pharmacy
Waldbaum's Pharmacy
Walgreens
Wal-Mart Pharmacy
Wegman Pharmacy
Weis Pharmacy
White Drug
Winn-Dixie
Yokes Pharmacy

*List subject to change. This is a partial listing only.

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Tarjeta temporal
para surtir por primera vez sus recetas en farmacias

Facilita la tarea de surtir las recetas correspondientes a la compensación por accidentes o enfermedades laborales.

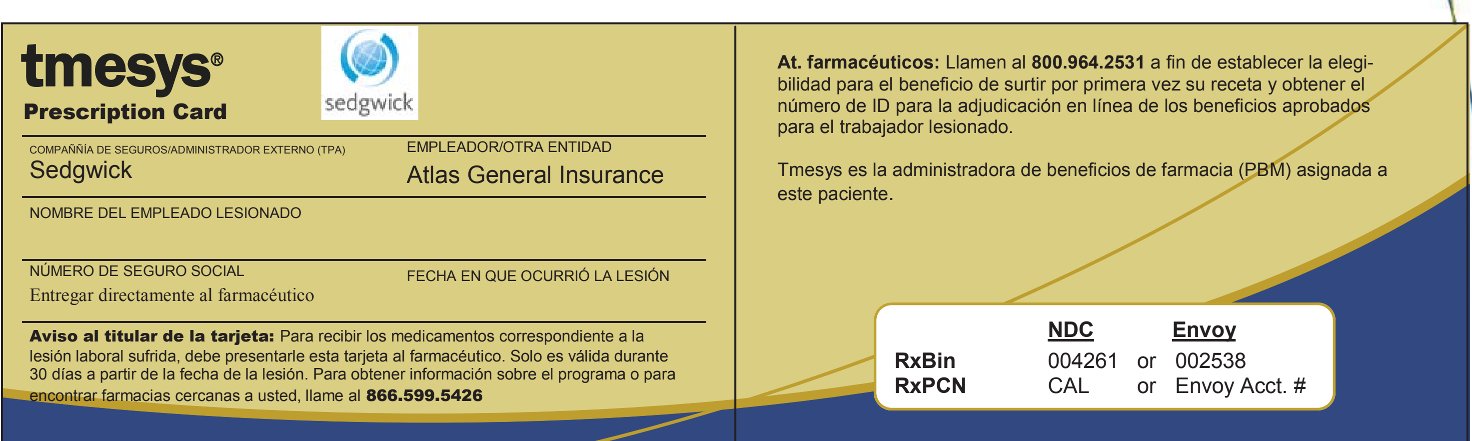
Sólo tienes que seguir estos sencillos pasos...

Empleador:

Imprima esta página inmediatamente después de recibir un aviso de lesión, complete la información que se encuentra a continuación y entréguesela a su empleado.

Empleado lesionado:

1. Si necesita que se le surta una receta por una lesión o enfermedad relacionada con el trabajo, diríjase a una farmacia de la red Tmesys.
2. Entréguele esta página al farmacéutico.
3. El farmacéutico le surtirá la receta sin costo alguno.



tmesys®
Prescription Card

COMPAÑÑÍA DE SEGUROS/ADMINISTRADOR EXTERNO (TPA)
Sedgwick

EMPLEADOR/OTRA ENTIDAD
Atlas General Insurance

NOMBRE DEL EMPLEADO LESIONADO

NÚMERO DE SEGURO SOCIAL
Entregar directamente al farmacéutico

FECHA EN QUE OCURRIÓ LA LESIÓN

Aviso al titular de la tarjeta: Para recibir los medicamentos correspondiente a la lesión laboral sufrida, debe presentarle esta tarjeta al farmacéutico. Solo es válida durante 30 días a partir de la fecha de la lesión. Para obtener información sobre el programa o para encontrar farmacias cercanas a usted, llame al **866.599.5426**

At. farmacéuticos: Llamen al **800.964.2531** a fin de establecer la elegibilidad para el beneficio de surtir por primera vez su receta y obtener el número de ID para la adjudicación en línea de los beneficios aprobados para el trabajador lesionado.

Tmesys es la administradora de beneficios de farmacia (PBM) asignada a este paciente.

	NDC		Envoy
RxBin	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #

(Si desea llevar la tarjeta en la billetera, corte a lo largo de la línea exterior y dóblela por la mitad)

Farmacéutico:

1. Llame al servicio de asistencia de farmacias de Tmesys al **800.964.2531.**
2. Suministre la información que figura arriba.
3. El servicio de asistencia le dará un número de ID correspondiente a la adjudicación.

Cómo encontrar una farmacia de la red

Para encontrar una farmacia de la red, use uno de estos sencillos métodos:

- Visite alguna de las siguientes cadenas de farmacias:

  Walgreens **Walmart** **Duane Reade** **Publix**
  Rite Aid **CVS** **Kroger** **Safeway**

- Use nuestro localizador de farmacias en línea: **www.pmsionline.com/pharmacy-center**.
- Llámenos: **866.599.5426**

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Red de farmacias minoristas de Tmesys* *Más de 65,000 farmacias, entre ellas grandes cadenas, así como farmacias independientes, lo cual permite que le puedan surtir sus recetas en la mayoría de farmacias del país.*

Accredo Health Group
Anchor Pharmacy
Arrow Prescription Center
Aurora Pharmacy
Baker's Pharmacy
Bartell Drugs
Bashas' United Drug
Bel Air Pharmacy
Big Y Pharmacy
Biggs Pharmacy
Bi-Lo
Bi-Mart
Bioscrip Pharmacy
BJ's Pharmacy
Brookshire's Pharmacy
Bruno's Pharmacy
Buehler's Pharmacy
Caremark Pharmacy
Carle Rx Express
Carrs Quality Center
City Market Pharmacy
Clinic Pharmacy
Coborn's/Cash Wise
Concord Drugs
Costco Pharmacy
Cub Pharmacy
CVS Pharmacy
D&W Pharmacy
Dahl's Pharmacy
Dierbergs
Dillon Pharmacy
Discount Drug Mart
Doc's Drug
Dominick's Finer Foods
Drug Emporium
Drug Mart
Drug Town
Drug Warehouse
Drugs For Less
E. W. James Pharmacy
Eagle Pharmacy
Eaton Apothecary
Econofoods Pharmacy
Edwards Pharmacy
Fagen Pharmacy
Family Drug Store
Family Fare Pharmacy
Family Pharmacy
Familymeds Pharmacy
Farm Fresh Pharmacy
Farmer Jack Pharmacy
Food 4 Less Pharmacy
Food City Pharmacy
Food Lion Pharmacy
Food Town Pharmacy
Food World Pharmacy
Fred Meyer Pharmacy
Fred's Pharmacy
Fruth Pharmacy
Fry's Pharmacy
Gemmel Pharmacy
Gentiva Health Services
Genuardi's Pharmacy
Gerbes Pharmacy
Giant Eagle Pharmacy
Giant Pharmacy
Glen's Pharmacy
Good Day Pharmacy
Grand Union Pharmacy
Gristedes Pharmacy
H-E-B Pharmacy
Haggen Foods
Hannaford
Happy Harry's
Harmons Pharmacy
Harps Pharmacy
Harris Teeter
Hartig Drug
Harvest Foods Pharmacy
Harveys Supermarket Pharmacy
Hen House Pharmacy
Hi-School Pharmacy
Homeland Pharmacy
Hometown Pharmacy
Hy-Vee Pharmacy
Ingles Pharmacy
Kmart Pharmacy
Kerr Drug
King Kullen Pharmacy
King Soopers Pharmacy
Kings Pharmacy
Kinney Drugs
Klingensmith's
Knight Drugs
Kohl's Pharmacy
Kohll's Pharmacy
Kopp Drug
Kroger Pharmacy
Lewis Pharmacy
Lifechek Drug
Longs Drug
Louis and Clark
Lowes Marketplace
Marc's Pharmacy
Marsh Drugs
Martin's Pharmacy
May's Drug Store
Med-Fast Pharmacy
Medical Arts Pharmacy
Medicap Pharmacy
Medicine Shoppe Pharmacy (various)
Med-X Drug
Meijer Pharmacy
Minyard Pharmacy
Morton Pharmacy
Mr. Discount Drugs
Navarro Discount Pharmacies
NeighborCare Pharmacy
No Frills Pharmacy
Network Pharmacy
Owens Pharmacy
P&C Food & Pharmacy
Pamida Pharmacy
Park Nicollet Pharmacy
Pathmark Pharmacy
Pavilions Pharmacy
PharmaCare Pharmacy
Pharmacy Express
Pharmacy Plus
Pick 'N Save Pharmacy
Piggly Wiggly
PrairieStone Pharmacy
Price Chopper Pharmacy
Price Cutter Pharmacy
Publix Pharmacy
Q Pharmacy
QFC Pharmacy
Quality Markets Pharmacy
QuickChek Pharmacy
QVL Pharmacy
Rainbow Pharmacy
Raley's Drug Center
Ralphs Pharmacy
Randalls Pharmacy
Reasors Pharmacy
Rite Aid Pharmacy
Ritzman Natural Health
Rosauers Pharmacy
RXD Pharmacy
Sack 'n Save Pharmacy
Safeway Pharmacy
Sam's Pharmacy
Save Mart Pharmacy
Save-Rite Pharmacy
Schnucks Pharmacy
Scolaris Pharmacy
Sedanos Pharmacy
Shaw's Pharmacy
Shaws/Osco Pharmacy
Shop 'n Save Pharmacy
Shopko Pharmacy
Shoppers Pharmacy
ShopRite Pharmacy
Snyder Drug Emporium
Southern Family Market
Star Pharmacy
Stop & Shop Pharmacy
Sunscript Pharmacy
Super 1 Pharmacy
Super D
Super G
Super Foodmart Pharmacy
Super Fresh Pharmacy
Super Rx Pharmacy
Sweetbay
The Pharm
Thriftway Drugs
Thrifty White Drug
Times Pharmacy
Tom Thumb Pharmacy
Tops Pharmacy
U-Save Pharmacy
Ukrops Pharmacy
United Pharmacy
USA Drug
Vix Pharmacy
Vons Pharmacy
VG's Pharmacy
Waldbaum's Pharmacy
Walgreens
Wal-Mart Pharmacy
Wegman Pharmacy
Weis Pharmacy
White Drug
Winn-Dixie
Yokes Pharmacy

*Lista sujeta a cambios. Ésta es sólo una lista

tmesys®
P.O. Box 152539
Tampa, FL 33684-2539

PERSONAL & CONFIDENTIAL
Important Insurance Claim Document Enclosed

tmesys®
Prescription Card
DOI «DOI»
ID# «subID»
Name «Patientname»
Carrier «Carrier»

tmesys®
Prescription Card
DOI «DOI»
ID# «subID»
Name «Patientname»
Carrier «Carrier»

Questions?

1.866.599.5426

¿Necesitas ayuda en español?
Llame al 1.866.599.5426

tmesys®
Prescription Card

	NDC		Envoy
RxBin	004261	or	002538
RxPCN	CAL	or	Envoy Acct.#
Issuer (80840)	9151014609		
Injury Date	«DOI»		
ID#	«subID»		
Name	«Patientname»		
Carrier/TPA	«Carrier»		

Prescription Delivery By Mail

In addition to providing access to your medications at a local pharmacy, Tmesys can also deliver your medications to your home through our PMSI Mail Order program at no cost. Using this convenient program means you will not have to drop off or pick up your prescription or wait in line while it is being filled.

For more information or to sign up, call **1.800.304.1764** or go to **www.pmsionline.com/pharmacy-center**, click on Mail Order Overview.

Attention Pharmacist: Tmesys is the workers' compensation PBM for this patient. For questions regarding transmission, call **1.800.964.2531**.

	NDC		Envoy
RxBin	004261	or	002538
RxPCN	CAL	or	Envoy Acct.#
Issuer (80840)	9151014609		

Attention Pharmacist: Tmesys is the workers' compensation PBM for this patient. For questions regarding transmission, call **1.800.964.2531**.

	NDC		Envoy
RxBin	004261	or	002538
RxPCN	CAL	or	Envoy Acct.#
Issuer (80840)	9151014609		

Note: Your use of this card is limited to those prescriptions medically related to an injury that is considered to be covered under the applicable state workers' compensation law.

Attention Pharmacist: Tmesys is the designated workers' compensation PBM for this patient. Call Tmesys with questions regarding transmission or rejection at: 1.800.964.2531.

Attention Cardholder: For questions regarding coverage or to find a pharmacy call Tmesys at: 1.866.599.5426 or visit www.tmesys.com.

IMPORTANT: ONCE CARDS HAVE BEEN REMOVED PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

Taking Care of <<PATIENTNAME>>

Using the Pharmacy Card

We want to make it easy for you to obtain the medication you need to recover from your work-related injury. Just follow these steps:

1. Activate the card by calling the toll-free number.
2. Separate the attached cards and place one in your wallet and one on your key ring.
3. Give a card to the pharmacist next time you have a new prescription or refill.
4. Your prescription will be filled at no cost.

Finding a Pharmacy

You can use any pharmacy that is part of the Tmesys network to fill your prescription—and with over 60,000 locations, the card is accepted at most pharmacies nationwide. Finding a network pharmacy is simple! Use one of the options below:

- Visit one of the following pharmacy chains:

  Walgreens **Walmart** **Duane Reade** **Publix**
  Rite Aid **Target** **Kroger** **Safeway**

- Go to one of these nearby pharmacies:

  «Pharmacy1»
  «Pharmacy2»
  «Pharmacy3»

- Look up a pharmacy on the website: **www.tmesys.com**, click on Pharmacy Locator and choose a search option.
- Call us toll free at **1.866.599.5426**.

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