Guidelines for Claim Reporting

How to Report a Claim:

In the event of a medical emergency an employee should be provided prompt medical care and should be referred to the nearest Emergency Medical Facility. Subsequently contact 1-2-1 Claims **immediately** at 1-877-411-4121.

If the injury is NOT a medical emergency:

- Immediately upon notification of an occurrence an Accident Loss Notice should be completed. Do not delay in reporting the claim, you will be notified of any additional information required to complete the loss notice form.
- The injured employee should complete the Employee Statement
- The HIPAA release should be signed
- Any Witnesses to the accident should complete a witness statement

Upon notification of a claim, 1-2-1 Claims will contact you to confirm receipt and gather any additional information necessary to process the claim.

Notice of a claim may be provided by mail, fax or telephone to:

1-2-1 Claims, Inc.
P.O. Box 2392
Boerne, Texas 78006

Phone # 210-695-6947
Toll Free 877-411-4121
Fax # 210-695-6932
Email: jlclaims@121claims.com

24 Hour Emergency Reporting 1-210-316-3781

Employee Statement

Employer:_____

Department/Division:_____

Employee name:_____

Last First Middle Initial

Phone:(___)_____-_____

Address:_____

Street Apt. #

_____

City St. Zip Code

Employee D. O. B.:_____ Social Security Number: _____

Date of Injury:_____ Time:_____ ☐a.m. ☐p.m.

Accident Information

Where did Injury Occur?_____

Describe Injury:_____

_____

_____

Area of body injured:_____

Witnesses: ☐Yes ☐No

Name(s): _____ _____

_____ _____

Employee Job Title:_____

Date reported to Supervisor:_____ Supervisor's Name:_____

Job being performed at time of Injury:_____

I certify this is a true and accurate report of the circumstances which occurred on the date of my injury stated above:

Signature of Injured Employee:_____

Date Signed:_____ Witness:_____

SUPERVISOR'S STATEMENT FORM

Employee Name: _____

Date and time of incident:_____

Where did it happen_____
street address or department/location at the time of injury

List witnesses and phone numbers, including anyone that may have knowledge of the incident, if known.

Name: _____ Phone #_____

Name: _____ Phone #_____

Did the employee lose any work time due to the alleged injury? ☐Yes ☐No

Did the employee go to the doctor? ☐Yes ☐No

Did the employee go to the doctor on own? ☐Yes ☐No

Treating Doctor's Name: _____ Phone #_____

Hospital Name: _____ Phone #_____

Has the employee returned to work? ☐Yes ☐No (as of date of this report)

How long is the employee expected to be off work? _____

What happened? (describe fully what took place or what caused you to make this investigation.)
_____
_____
_____
_____
_____
_____

Date and time employee reported incident to manager/supervisor_____

Investigated by: _____Title_____Date_____Phone #_____

_____ _____
Supervisor's signature Date

WITNESS STATEMENT

Injured Employee's Name: _____ Incident date and time:_____

Company Name: _____

Witness name: _____

Address:_____ Phone #_____

Where did the injury happen? _____
Street address or department/location at the time of injury

Are you related to the injured employee? ☐Yes ☐No - If "yes", how?_____

Same employer as injured employee? ☐Yes ☐No - If "no", employed by: _____

Did you actually see this injury happen? ☐Yes ☐No - If "no", how do you know about it?
_____
_____
_____

Please explain in detail what you know about this incident:
_____
_____
_____

Did this employee ever talk with you about getting hurt on the job? ☐Yes ☐No

If "yes", when did this conversation take place?_____ Date _____Time_____

What did the employee say?_____
_____
_____

Do you know of any other injury, accident or illness this employee has had? ☐Yes ☐No
If "yes", explain:_____
_____
_____

Give the names of any other persons who might know about this accident/injury:
_____ _____

Additional comments:
_____
_____
_____

Signature of Witness:_____ Date Signed:_____

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Plan Participate Name: **Date of injury:**

Authorization: I hereby authorize any physician, hospital, pharmacy, health care provider, other health care facility, insurance company, prior employer or (specific any additional persons) _____ to use with, and disclose any of my medical records or other protected health information to, the following representative of the **1-2-1 Claims, Inc.** (the "Plan"): (1) any claims adjuster, claims manager or authorized staff member of 1-2-1 Claims Inc and (2) The employer's representative **and appeals committee members** and their authorized staff members.

I further authorize such healthcare providers, persons and Plan representatives to use with, and disclose such protected health information to (1**) 1-2-1 Claims, Inc.'s authorized representative**, authorized employees of the employers Human Resources, Risk Management, Safety Legal, Accounting/Payroll Employee Benefits and Information Technology (IT) Departments] (2) Supervisors **AND OR OTHER FIELD REPRESENTATIVES** (3) The Plan's Privacy Officer, (4) any medical case management group, repricing company, insurance agent, insurance carrier, consultant, attorney, business associate or other persons authorized by the employer or 1-2-1 Claims, Inc. to perform business or legal services in connection with my work-related incident referenced above and (5) (specify any additional persons: _____.

Purpose of Authorizations: I understand that this Authorization is given for the following purposes only: (1) the treatment of any occupational illness/injuries allegedly arising from my work-related incident referenced above, such as discussion of my diagnosis, treatment, prognosis and overall health condition; (2) the payment of any claim for Plan benefits, such as pre-authorization of medical treatment, case management and making benefit determinations; (3) the health care operations of the Plan, such as claims audits, coordination of benefits/subrogation and the renewal or replacement of Plan related insurance; (4) the assessment of my ability to qualify for a leave of absence or return to full or modified job duties; (5) the use and disclosure of post-accident drug & alcohol test results; (6) assisting me (or my Authorized Representative below) with benefit claims or other Plan-related issues; (7) liability and safety evaluations and activities, and (8))please specify and additional reason(s))_____.

Acknowledgement: By signing below, I understand and acknowledge that (1) this authorization shall expire on the date upon which I am no longer eligible for plan benefits; (2) I have the right to revoke this Authorization by contacting the following person in writing **1-2-1 Claims, Inc. P O Box 2392, Boerne, Texas 78006** - however, this revocation will not apply to any use or disclosure made prior to the plan's receipt of my revocation; (3) the Plan may not condition treatment, payment, enrollment or eligibility for benefits solely on whether I sign this Authorization; (4) there is a potential that my protected health information used and disclosed in accordance with this Authorization may be re-disclosed by certain persons receiving this information and may then no longer be protected by federal law and (5) I am entitled to a copy of this Authorization and that a photocopy of this Authorization shall be considered as effective as the original.

PLAN PARTICIPANT SIGNATURE_____DATE_____

WITNESS SIGNATURE_____DATE_____

Texas Work Injury Plan Employee Incident Report

Employer Information

Date____/____/___

Employer's Name: _____

And Address: _____Contact:_____

Employers Phone #:_____/_____/_____ Employers Fax #_____/_____/_____

Policy #_____

Employee Information

Employee's Name_____

And Address: _____

Employee's phone #:_____-_____-_____Employee's Date of Hire:____/_____/_____

Employee's occupation:_____Employee's weekly pay rate:__$_____

Employee's SSN_____-_____-_____ Date of Birth ___/___/___ Male/Female_____

Accident information

Date of loss_____ Time of day of accident:__:____Date lost time began___/___/___

Date returned to work ___/____/___ Date reported to employer____/_____/_____

Supervisor's Name:_____Address where accident occurred:_____

Witness:_____Have you ever been treated for a similar injury Y___N_____

Physician's Name & Address_____

Description of
Accident:_____

_____

_____

Nature of injury (Body Part):

I certify that the above information is true and correct to the best of my knowledge. I understand that if I am declining medical treatment at this time that my Employer will not be responsible for any expense related to the Incident or any resulting injury. I further understand that I will not be eligible for benefits under the plan unless I receive medical care from an approved provider within 14 days from the date of incident.

Employee's Signature: _____ Date: _____

Offer of Medical Treatment Declined

I, _____ declined medical treatment on this date of ___/___/___ for an accident and any resulting injury sustained on the date of ___/___/___.

I am aware that my employer, _____, will not be responsible for any medical expenses, unless specifically pre-approved.

_____

Employee Signature Date

_____

Witness Signature Date