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INJURED WORKER PACKET

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State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* _____
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

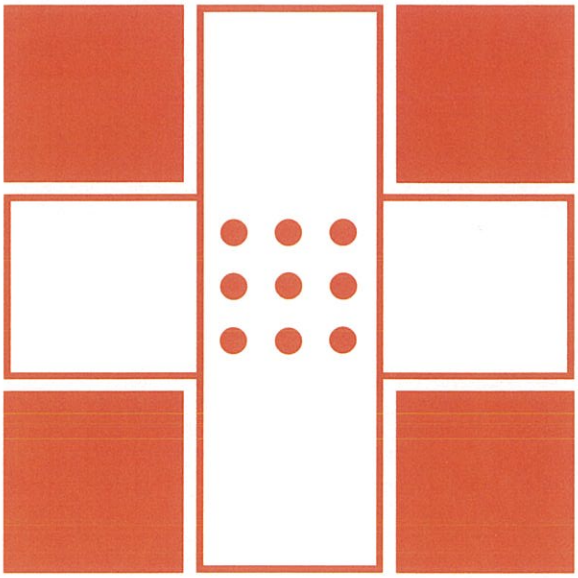
Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/ *Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*



FACTS FOR INJURED WORKERS

MEDICAL AUTHORIZATION

To: LWP Claims Solutions, Inc.

I, _____ hereby authorize the following medical providers (medical provider is defined as any acupuncturist, clinic, chiropractor, physical therapy provider, primary physician, or specialist who has administered medical treatment to me) to disclose their entire medical file and any other protected health information concerning me to LWP CLAIMS SOLUTIONS, INC. and its agents, employees and representatives. The protected health information to be disclosed includes medical records; doctors notes; laboratory records/reports; diagnostic test reports/films; photographs; bills/statement of charges; and, all documentation pertaining to history, examination, diagnosis, condition, etiology, prognosis, treatment and care.

Facility / Physician Name	Address	City	State	Zip	Phone	First Treatment Date	Last Treatment Date

This authorization complies with the HIPAA Privacy Rule

MEDICAL AUTHORIZATION

This authorization also includes disclosure of information on the diagnosis and treatment of:

	Yes	No
Mental illness including psychiatric/psychological treatment	[ ]	[ ]
Alcohol, drugs and tobacco	[ ]	[ ]
HIV infection and sexually transmitted diseases	[ ]	[ ]

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction except those outlined above. This protected health information is to be disclosed under this authorization at my request, as permitted by §164.508(c)(1)(IV) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to LWP CLAIMS SOLUTIONS, INC. or by sending a written revocation directly to My Providers. I further understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization. I understand that any information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, LWP CLAIMS SOLUTIONS, INC. agrees to protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policy.

I understand that My Provider may not refuse to provide treatment or payment for health care because I refused to sign this Authorization. I acknowledge that I have received a copy of this Authorization.

_____
Signature

_____
Print Name

_____
Date

_____
Date of Birth

_____
Social Security Number

This authorization complies with the HIPAA Privacy Rule

LWP

PROGRESSIVE Medical, Inc.

Prescription Authorization
LWP Claims Solutions, Inc/Workers' Compensation

LWP Claims Solutions, Inc. and Progressive Medical, Inc. have joined together to provide your eligible injured parties with a First Fill® prescription medication card program. At the bottom of this form is a First Fill® medication card that enables injured parties to obtain the "initial" prescription(s) needed upon injury, with little to no out–of–pocket expense.

Instructions for Company to use this First Fill® card:

- Injury occurs and a report of injury is made to the appropriate personnel.
- Fill in the eligible injured party's name, social security number, employer, date of birth, gender and date of injury on the form below.
- After explaining the instructions for this card, please give the eligible injured party this document.
- Instruct the eligible injured party to take the First Fill® card and their prescription to the pharmacy.
- Report the claim to the appropriate insurance company/TPA.
- The pharmacist fills the medication; the bill is processed and sent to Progressive Medical.
- The First Fill® card is available for a one time use.

**Please note: If additional, ongoing medication is required, the claims handler should contact Progressive Medical to utilize our Retail Medication Card Program.

Injured Party:

At the bottom of this form is a First Fill® Card that will enable you to obtain the "initial" prescription(s) needed upon injury with little to no out-of-pocket expense. A sample list of "Participating Pharmacy Chains" that accept this First Fill® card is also included below.
This card is for a one time use to receive your medication(s) per your employer/insurance company.
Use of this card is restricted to your allowed condition.
To receive this benefit, present this card to a participating pharmacy along with your prescription from your Doctor.
If you have any questions, call Progressive Medical, toll free, at 1-888-909-MEDS. Out Client Service Specialists are available 24-hours a day to take care of your needs.

**Please note: If your claim is accepted, you will receive a retail pharmacy card in the mail. Present that card when filling subsequent related prescriptions.

Participating Pharmacies:

Brooks Pharmacy	**CVS Pharmacy**	**Eckerd Pharmacy**	**Giant Eagle Pharmacy**
Harris Teeter Pharmacy	**Kmart Pharmacy**	**Kroger Pharmacy**	**Longs Drugs**
Rite Aid Pharmacy	**Walgreens Pharmacy**	**Wal-Mart Pharmacy**	**Winn Dixie Pharmacy**

For additional pharmacies in your area, please visit www.progressive-medical.com. Select the Total Pharmacy Management option, then select the Pharmacy Locator. Enter your City, State, or Zip Code and click the locator button. You will see a listing of all participating pharmacies within your specified area.

Instructions for Pharmacist:

LWP Claims Solutions, Inc. participates with Progressive Medical in an online pharmacy benefit program. This form is valid for Workers' Compensation prescriptions only.

Please transmit all claims online to Progressive Medical:

Bin #: 600471
Process Control #: 7777
Group #: _____

For all other questions call toll-free the Progressive Medical Pharmacy Help Desk at **1-888-908-6337**.

Injured Worker Information:

Name of Eligible Injured Party: _____

ID/Auth # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
(Combination of Social Security Number – 9 digits, no dashes, and today's date/date of injury – 6 digits, no dashes; ie., Social Security Number of 123-45-6789 and Date of Injury July 17, 2006 would be the ID# 123456789071706)

Date of Birth: _____ Gender: _____

Employer: _____

Autorización de medicamentos recetados
LWP Claims Solutions, Inc/Compensación del seguro obrero

LWP Claims Solutions, Inc. y Progressive Medical, Inc. se han unido para proporcionar a las personas lesionadas que califican un programa de tarjeta de medicamentos recetados "First Fill®". A pie de página figura una tarjeta de medicamentos First Fill® que permite a las personas lesionadas obtener la receta o recetas "iniciales" necesarias después de sufrir una lesión sin gastos de su propio bolsillo o con muy pocos gastos.

Instrucciones para que la Compañía use esta tarjeta First Fill®:

- Se produce una lesión y se notifica dicha lesión al miembro del personal correspondiente.
- Se llena el nombre de la persona lesionada que califica, su número de seguro social, empleador, fecha de nacimiento, sexo y fecha de la lesión.
- Después de explicar las instrucciones referentes a esta tarjeta, se da este documento a la persona lesionada que califica.
- Se indica a la persona lesionada que califica que lleve la tarjeta First Fill® y la receta a la farmacia.
- Se notifica la reclamación a la compañía de seguros o TPA (administrador de terceros) correspondiente.
- El farmacéutico surte la receta, se procesa la factura y se envía a Progressive Medical.
- La tarjeta First Fill® está disponible para usarse sólo una vez.

**Nota: Si se requieren más medicamentos para continuar el tratamiento, el encargado de las reclamaciones debe comunicarse con Progressive Medical para utilizar nuestro Programa de Tarjeta para Medicamentos al Por Menor.

Persona lesionada:

A pie de página figura una tarjeta First Fill® que le permitirá obtener la receta o recetas "iniciales" necesarias después de sufrir una lesión sin gastos de su propio bolsillo o con muy pocos gastos. Se incluye más adelante una lista de las "Cadenas farmacéuticas participantes" que aceptan esta tarjeta First Fill®.
Esta tarjeta es para usarse una vez con el fin de recibir el medicamento o medicamentos según su empleador/compañía de seguros
El uso de esta tarjeta se limita a la lesión/problema médico permitido.
Para recibir este beneficio, presente esta tarjeta en una farmacia participante junto con la receta de su médico.
Si tiene alguna pregunta, llame gratis a Progressive Medical al 1-888-909-MEDS. Nuestros especialistas en servicio al cliente se encuentran a su disposición las 24 horas del día para atender sus necesidades.

**Nota: Si se acepta su reclamación, recibirá por correo una tarjeta para farmacias minoristas. Presente esa tarjeta al surtir recetas posteriores relacionadas.

Farmacias participantes:

Brooks Pharmacy	**CVS Pharmacy**	**Eckerd Pharmacy**	**Giant Eagle Pharmacy**
Harris Teeter Pharmacy	**Kmart Pharmacy**	**Kroger Pharmacy**	**Longs Drugs**
Rite Aid Pharmacy	**Walgreens Pharmacy**	**Wal-Mart Pharmacy**	**Winn Dixie Pharmacy**

Si desea conocer otras farmacias en su área, visite www.progressive-medical.com. Seleccione la opción *Total Pharmacy Management* (Gestión total de farmacias) y, seguidamente, seleccione *Pharmacy Locator* (Localizador de farmacias). Introduzca su ciudad, estado o código postal y haga clic en el botón del localizador. Verá una lista de todas las farmacias participantes en un área específica.

Instructions for Pharmacist:

LWP Claims Solutions, Inc. participates with Progressive Medical in an online pharmacy benefit program. This form is valid for Workers' Compensation prescriptions only.

Please transmit all claims online to Progressive Medical:

Bin #: 600471
Process Control #: 7777
Group #: A290

For all other questions call toll-free the Progressive Medical Pharmacy Help Desk at **1-888-908-6337**.

Información sobre el trabajador lesionado:

Nombre de la persona lesionada que califica: _____

No. de ID/Autorización ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
[Combinación del número de seguro social (9 dígitos, sin guiones) y la fecha de hoy/fecha de la lesión (6 dígitos, sin guiones); por ejemplo, el número de seguro social 123-45-6789 y la fecha de lesión del 17 de julio de 2006 daría el número de ID 123456789071706].

Fecha de nacimiento: _____ Sexo: _____

Empleador: _____

EMPLOYER'S APPROVAL FOR MEDICAL ATTENTION

Employee's Name: _____

Employer: _____

Date of Injury: _____

Part(s) of Body Injured: _____

Employer-designated treating physician or facility:

_____

- ***Employee***: Please take this form with you to medical facility indicated above.

- ***Notice to Preferred Provider***: This letter will serve as approval for the above named employee to receive initial treatment required to cure or relieve him or her from the affects of their industrial injury. Our insurance carrier and/or claims administrator reserves the right to determine if further treatment is work-related and/or reasonable or necessary.

  Please submit the Doctor's First Report of Injury, Form 5021, to:

LWP CLAIMS SOLUTIONS
P.O. BOX 349016
SACRAMENTO, CA 95834-9016

Phone: (916) 609-3600 ***Fax: (408) 725-0395***

LWP

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Covered Employee Notification of Rights Materials

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