WORKPLACE INJURY TRIAGE & REPORTING

Help within seconds: How it works.

STEP ONE
Employee informs supervisor of injury.

STEP TWO
If injury is not life threatening, supervisor telephones Medcor's Triage 24-hour toll-free number.

STEP THREE
Medcor's experienced medical professional asks appropriate questions using a proprietary protocol developed by Medcor's medical director, based on experience handling more than one million workplace injuries and illnesses. (Multi-language capabilities are available as well.)

STEP FOUR

The Registered Nurse recommends a course of action including:

- On-site first-aid treatment procedures.
- Or, if needed, referral to a designated medical facility for treatment, including pre-arranged transportation procedures.

STEP FIVE
The triage nurse alerts the medical provider of the patient's expected arrival via fax to help ensure continuity of care and costeffective treatment.

STEP SIX
The triage nurse enters relevant information into a database for company reports to be distributed to all necessary via secure link emailing.

Working for You

Companies and Municipalities that have realized the benefits of Medcor's Triage services range in size from 10 to 100,000 employees and include:

- Cities and Municipalities
- Chains of company-owned or franchised retail facilities such as fast-food outlets, national department or discount stores, and auto service centers.
- Large facilities that have too few accidents to justify on-site medical care.
- Companies with mobile or nationwide workforces, such as trucking, repair and delivery services.
- Large facilities that have on-site medical care during day shifts but rely on Medcor's On-Line services for nights or weekends.
- National or regional multi-site construction operations.
- Small to medium-size manufacturing facilities.

The odds are good that Medcor's On-Line services can work for your firm as well.

1.833.292.4764
24 HOURS A DAY/7 DAYS A WEEK

IPMG

ICRMT
WC Supervisor Report
(to be completed by supervisor of injured employee)

Injured Employee Name: _____ SSN: _____

Employee Home Phone: _____ Employee's approximate weekly wage: _____

Supervisor's Name and Title: _____

Date/Time of Accident: _____ Date/Time Employee Reported: _____

Medical Expenses so far (if known): _____

Did/will employee lose time from work as a result of this accident? ☐ Yes ☐ No

If yes, please list dates/timeframes missed due to this accident: _____
If lost time: Did or will the lost time exceed 3 consecutive scheduled work shifts? ☐ Yes ☐ No
Is there a possibility of accommodating a modified duty position during any recovery period? ☐ Yes ☐ No

If no, reason why: _____

Was medical treatment performed outside of the employer's facility? ☐ Yes ☐ No

If yes, was this medical provider (select all that apply): ☐ Occupational Health Provider
☐ Chosen by employee
☐ Other

Did the employee see more than one physician for this accident? ☐ Yes ☐ No

What object or substance, if any, directly harmed the employee? _____

_____

Did the accident occur on the employer's premises? ☐ Yes ☐ No

Please review the employee's report of injury. Do you agree with the employee's details of this accident? ☐ Yes ☐ No

If no, please explain thoroughly (use 2nd sheet if necessary): _____

_____

_____

What did the employee tell you regarding what happened for the incident to occur? _____

_____

_____

What was the sequence of events that led up to the accident? What material, equipment and tools were involved? _____

_____

What were the environmental conditions at the accident site? _____

What was done immediately after the accident? _____

Specify body parts injured in this accident: _____

Injury Type (i.e. sprain, fracture, etc.): _____

Accident Location: _____

Loss Causation: _____

What conditions or actions contributed to the accident? _____

What system design and implementation problems contributed to the accident occurrence? _____

What actions will be taken to reduce unsafe conditions and actions? _____

What actions will be taken to strengthen system design and implementation? _____

Would you like Method Management to contact you for further risk management assistance? ☐ Yes ☐ No

Do you believe an outside/3rd party is responsible for this accident occurring? ☐ Yes ☐ No

If yes, please indicate the responsible party's name, address and phone number if known: _____

I agree the above is true and accurate

Supervisor Name: _____ Supervisor Phone: _____

Supervisor's Signature: _____ Date: _____

ICRMT
WC Employee Injury Report
(to be completed by injured employee)

Your Name: _____ Home Phone: _____

Hire Date: _____ SSN: _____ Date of Birth: _____

Home Address & Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced # Dependents: _____

Date/Time of Incident: _____ Time Shift Began: _____ Date/Time Reported: _____

Address of accident occurrence: _____

Body part and how it was affected: _____

_____

What were you doing when the accident occurred? _____

Reason for being in the area: _____

_____

How did the accident occur ? (use 2nd sheet if necessary): _____

_____

_____

Who else saw the incident? _____

To whom did you report the incident? _____

Have you received first aid? ☐ Yes ☐ No Were you treated in the Emergency Room? ☐ Yes ☐ No
If yes, check One: ☐ On Premise Were you hospitalized overnight as an inpatient? ☐ Yes ☐ No
☐ Outside medical assistance Has your doctor taken you off of work? ☐ Yes ☐ No
☐ Both

When is your next medical appointment? _____

Name, address, phone and fax # (if available) of medical facility where treatment was sought: _____

_____

Date/Time of such treatment: _____

Prior Workers' Compensation Claims? ☐ Yes ☐ No

If yes, please explain using 2nd sheet if necessary (i.e. date, body part, injury specifics): _____

_____

_____

I agree the above is true and accurate

Employee's Signature: _____ Date: _____

IPMG
INSURANCE PROGRAM MANAGERS GROUP

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Participant Name:	Address, City, ZIP:	Birth Date:

I hereby authorize my identified health care provider(s) to release and disclose the medical information and other records listed below that may include Protected Health Information about me to IPMG Employee Benefits Services (IPMG), at 225 Smith Road, St. Charles, IL 60174. "Protected Health Information" or "PHI" includes any information that relates to (1) My past, present or future physical or mental health or condition; or (2) Health care I have received or will receive; or (3) Payment for health care I have received or will receive.

Purpose of Disclosure. All such medical information and PHI may be disclosed by verbal/oral, email, or other form of written communication to IPMG and/or individuals working on its behalf for purpose of informing them of my medical condition and treatment, as reasonably requested for workers' compensation purposes, certification and payment of medical expenses, and discharge planning, ongoing case management, wellness service coordination, and other integrated care management services as disclosed to me by IPMG at the time of this Authorization.

The following specific information to be disclosed:

[ ] All medical and billing records or any other information maintained by you (including records prepared by others that are in your possession) regarding the above listed Participant;

or only the following:

[ ] Health Treatment [ ] Dental Treatment [ ] Vision Treatment

[ ] Other _____

[ ] Records related to the following treatment: _____

[ ] Related to the following time period(s): _____ to _____

I understand that the records to be disclosed pursuant to this Authorization may contain records or information relating to treatment or participation in the following: *Initials*

√ Federally assisted drug or alcohol abuse programs _____

√ HIV Testing or HIV or AIDS Status _____

√ Diagnosis and Treatment of Mental or Psychological Health _____

√ Genetic testing information and/or records _____

I understand that such information is subject to special protections pursuant to state and federal laws. By my initials, I authorize the use or disclosure of such records if they are otherwise included within the scope of this Authorization

I understand that IPMG shall be authorized to use and disclose my PHI in the manner provided under applicable law, including the Health Insurance Portability and Accountability Act (HIPAA), as described in its *Notice of Privacy Rights*. I have the right to revoke this Authorization in writing, except to the extent the provider has taken action in reliance upon this Authorization. I also understand a photocopy or facsimile of this Authorization shall be considered as effective and valid as the original. I understand that I may see and copy the information described on this form if I ask for it, and that I may obtain a copy of this form after I sign it. *I understand that this Authorization is voluntary and that I may refuse to sign this Authorization*. My refusal to sign will not affect my ability to seek and receive treatment, payment for submitted claims or maintain other eligibility for any other coverage provided under my employer's employee benefit plan(s).

I understand that my Protected Health Information may also be used or disclosed for purposes of responding to the lawsuit or claim brought by me or involving me. I understand that my PHI may be made available to various parties also involved with or defending such legal action by me or involving me, and that the information, once disclosed, might no longer be subject to certain state or federal privacy protections once released.

With respect to PHI or other information provided for or by my group health plan for health benefit purposes only, this Authorization expires on the earlier of _____, 201__ or the following event:_____ _____, but such expiration will not be effective as to records already released in reliance on the Authorization.

_____ _____

Signature of Participant or Personal Representative Date

Personal Representative Section

If a Personal Representative executes this form, that Personal Representative warrants that he or she has authority to sign this form on the basis of:

☐ Legal Authority (Power of Attorney, etc.) Please attach documentary evidence.

☐ Parent, Guardian or other individual acting *in loco parentis*

☐ Written Designation by the Patient or Participant

ICRMT
WC Witness Report
(to be completed by accident witness)

Injured Employee Name: _____

Your Name: _____ Your Phone Number: _____

Your Address: _____

Your relationship with injured employee (check one): ☐ Co-worker ☐ Other

Date/Time of Incident: _____ Today's Date/Time: _____

What was the employee doing at the time of the accident? _____

_____

What was the sequence of events that led up to the accident? _____

_____

_____

What was done immediately after the incident? _____

_____

_____

What were the environmental conditions at the accident site? _____

_____

What materials, equipment and tools were involved? _____

_____

I agree the above is true and accurate

Witness Name (please print): _____

Witness' Signature:_____ Date: _____