

How to Report a Work-Related Injury

In the event of a medical emergency, have the employee seek immediate care at the nearest emergency medical facility.

The more information you have before placing the call, the less time the call will take.

- **Get the facts regarding the injury.**
- **Obtain the employee's personnel file, whenever possible.**
- **Gather the information listed below before calling to report your loss.**
- **Report claims immediately. Loss reporting is available 24 hours a day, 365 days a year at 1-800-327-3636.**

The Hartford's representative will ask you for the following information:

Your Company Information

- Account number and location code
- Parent company name (or program name)
- Policy number

Injured Worker Information

- Name, date of birth, address, phone number
- Social Security number
- Age, gender, marital status
- Number of dependents
- Hire date/years in current position
- Latest wage information

Details of the Incident

- When was the accident reported to you, and by whom (time, date)?
- Address where injury occurred?
- Type of injury (cut, burn, etc.)?
- Exact body part injured?
- What was the cause of the accident (slip & fall, struck by object, etc.)?
- Do you have any reason to question this injury?
- What are the estimated number of days the employee will lose due to injury?
- What is the anticipated date of return to work?

- Did anyone witness the accident? Who?
- Where was the injured employee treated (name, address, phone number of medical provider or facility)?

Network Providers

Upon request or at the time of injury, our representatives can supply you with the name and address of network providers in your area, capable of treating your employee's work-related injuries.

Expediting the Loss Reporting Process

The claim representative's top priority is to investigate and resolve the claim — quickly and fairly. Research has proven that the earlier a loss is reported, the quicker the claim can be resolved, and the lower the overall claim will cost.

Before the end of your call, you'll receive a claim number and all information will be transmitted to the appropriate Hartford claim office.

To contact The Hartford from Canada, please dial 1-800-834-5548.

Early Loss Reporting

The only number Hartford customers need to report an injury

1 • 800 • 327 • 3636

Account Number: _____

Parent Company Name
(or program name): _____

Policy Number or Location Code: _____





Telephonic Reporting: 1-800-327-3636
Workers' Compensation Call-In Script

The following script contains the comprehensive list of questions that you will be asked when calling in a claim report to LossConnect. Asterisks denote information that is critical to proper handling office assignment. Please be sure to obtain this information prior to calling in a claim.

Preparer Information			
Preparer Name:		Preparer Phone:	
Filing State: *		Employee Social Security Number:	
Employee Name:		Location Address:	
Date of loss:		Time of loss:	
Employer/Loss Location Information			
Policy Number: *	Account Number: *	Location Code:	
Account Name:		Employer Name:	
Address:		City:	State: Zip Code:
Contact Work Phone:		FEIN:	
Location Name:			
Address:		City:	State: Zip Code:
Is this the employer's address? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Employee Information			
Job Classification Code:			
Employee Address:		City:	State: Zip Code:
Home Phone:	Work Phone:	Alt Phone:	
Date of Birth:	Age:	Gender:	Marital Status:
Number of Dependents:		Primary Language:	
Circle Correct Answer For Each: Is Employee a Partner: <input type="checkbox"/> Yes <input type="checkbox"/> No Owner: <input type="checkbox"/> Yes <input type="checkbox"/> No Officer: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Supervisor Name:		Supervisor Phone:	
Employment Information			
Date of Hire:	State of Hire:	Length of Employment:	

Date in Job:	Length in Current Job:	Employment Status:		
Job End Date:	Hours Per Day:	Days Per Week:		
Hours Per Week:	Pay Type:	Hourly Wage:		
Daily Wage:	Weekly Wage:	Monthly Wage:		
Gross Wages 30 days prior to accident: (AZ only)				
Average Weekly Wage:		Gross Wages 30 Days Prior to Accident:		
Time Shift Begins:		Time Shift Ends:		
Regular Days Off (check): <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun				
Other Payments Not Reported:	Amount:	How Often is Other Payment Received: (Monthly, weekly, other)		
Does Employee Consistently Receive Overtime:	Amount:	How is Overtime Payment Paid: (Monthly, weekly, other)		
Date Injury Reported to Employer:		Employee Status at Time of Reporting: (CA only)		
Date claim form provided to employee: (CA only)				
Loss Information				
Loss Description (what was employee doing at time of injury):				
Nature of injury:		Fatality Date:		
Next Of Kin Information				
Next of Kin name:	Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:	Alt Phone:		
Relationship to Employee:				
Injury Information				
Has Employee previously reported a claim:		Loss Date:		
Status:		Body Part:		
Has Employee missed time from work, or are they expected to? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did Employee receive medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date returned or expected date to return:		First Date Missed:		
Does employee have a Group Health Provider: (OR only)		If yes, name of Group health provider:		
Fifth day incapacity date: (MA only)				
Initial Treatment Information				
Initial Treatment:				
Taken by Emergency Transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Airlifted/Medivac? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Facility Name:	Address:	City:	State:	Zip Code:

Phone:		Facility Type:		Treating Physician:	
Type of Medical Treatment Received:					
Admitted to Hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Date Admitted:		Still in Hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Intensive Care Unit: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			Burn Unit: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Additional Treatment					
Physician Name:		Address:		City:	State: Zip Code:
Phone:			Specialty Type:		
Type of Medical Treatment Received or Expected:					
Incident Information					
Time Employee Began Work:			Time Incident Reported:		
Department Where Injury Occurred:			Were Safeguards or Safety Equipment provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Were Safeguards or Safety Equipment Used: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk					
Is the purpose of this claim a possible Dispute? (LA only) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			OSHA log Number: (UT only)		
Labor and Industrial claim number: (WA only)			UBI Number (WA only)		
Could the employee have prevented the Accident: (VT only)			Could the employer prevent this type of accident: (VT only)		
Additional Incident Information					
Was a Machine Part Involved:					
Was Machine Part Defective:			In What Way Was the Machine Defective:		
Is The Claim Questionable:			Signs of Alcohol or Drug Use:		
Was Employee Engaged in an Unsafe Activity: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			Describe Unsafe Activity:		
Responsible Party (if applicable)					
Responsible Party Name:			Address:		
City:	State:	Zip Code:	Phone:		
Witness Information (if applicable)					
Witness Name:		Address:		City:	State: Zip Code:
Home Phone:		Work Phone:		Alt Phone:	
Contact Information					
Name:		Address:		City:	State: Zip Code:
Work Phone:		Alt Phone:		Fax Number:	
Email Address:		Contact Person's Title:		When To Contact:	

Additional Information

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Jurisdictional Information
(Submit only for applicable states)

Nevada	
How is employee paid: (check one) <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Other	
Day of week pay period ends: (check one) <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat	
Are scheduled days off rotating: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If part time, how many hours a week was the employee hired: _____ hrs
How many months has the employee been Employed by the current employer in NV: _____ months	OSHA log number: _____
Was more than one person injured in the Accident: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Supervisor that injury or occupational disease was reported to: _____
Was employee in your employ when the injured or disabled by occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did employee return to next scheduled shift after accident: <input type="checkbox"/> Yes <input type="checkbox"/> No
Will you have light duty work available if necessary: <input type="checkbox"/> Yes <input type="checkbox"/> No	Last day wages earned: _____
Unemployment Compensation received during last 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No	If validity of claim is doubted, state reason: _____
New Hampshire	
Is a NH youth employment certificate on file: <input type="checkbox"/> Yes <input type="checkbox"/> No	Estimated length of disability: _____
Number of full time employees: _____	Number of part time employees: _____
Is there a written safety program: <input type="checkbox"/> Yes <input type="checkbox"/> No	Is there an active Safety Committee: <input type="checkbox"/> Yes <input type="checkbox"/> No
Managed Care Program: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Managed care provider name: _____
Texas	
Does Employee speak English: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, native language: <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Italian <input type="checkbox"/> Polish <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic	
Tax ID number: _____	Last paycheck amount: _____
Last pay period hours worked: _____	Last pay period days worked: _____
Accident prevention services requested in past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Accident prevention services received: <input type="checkbox"/> Yes <input type="checkbox"/> No

Workers' Compensation Claim Center Locations

Best Outcomes For Your Business

- Aurora:** **Address:** 4245 Meridian Parkway, Aurora, IL 60504
Mailing Address: P.O. Box 400, Shawnee Mission, KS 66201
Toll-Free: 877-952-9222 **FAX:** 877-905-3340
Satellite Office to our Kansas City Workers' Compensation Claim Center
- Baltimore:** **Address:** Center Pointe Building, Shawan Center, 200 International Circle,
 Hunt Valley, MD 21030
Mailing Address: P.O. Box 958459, Lake Mary, FL 32795
Toll-Free: 877-673-9222 **FAX:** 860-757-5991
Satellite Office to our Orlando Workers' Compensation Claim Center
- Charlotte:** **Address:** 5832 Farm Pond Lane, Beaufort Building, Suite 400,
 Charlotte, NC 28212
Mailing Address: P.O. Box 958459, Lake Mary, FL 32795
Toll-Free: 877-673-9222 **FAX:** 860-757-5991
Satellite Office to our Orlando Workers' Compensation Claim Center
- Hartford:** **Address:** 55 Farmington Avenue, Suite 301, Hartford, CT 06105
Mailing Address: P.O. Box 4771, Syracuse, NY 13221
Toll-Free: 877-469-9222 **FAX:** 877-536-3201
Satellite Office to our Syracuse Workers' Compensation Claim Center
- Houston:** **Address:** 785 Greens Parkway, Suite 210, Houston, TX 77067
Mailing Address: P.O. Box 4626, Houston, TX 77210
Toll-Free: 877-889-9222 **FAX:** 877-538-8966
Covering: AR, AZ, CO, LA, ID, MT, NM, OK, TX, UT, WY
- Kansas City:** **Address:** 7300 West 110th Street, Overland Park, KS 66210
Mailing Address: P.O. Box 400, Shawnee Mission, KS 66201
Toll-Free: 877-952-9222 **FAX:** 877-905-3340
Covering: IA, IL, IN, KS, KY, MI, MN, MO, ND, NE, OH, SD, WI
- Orlando:** **Address:** 200 Colonial Center Parkway, Suite 500, Lake Mary, FL 32746
Mailing Address: P.O. Box 958459, Lake Mary, FL 32795
Toll-Free: 877-673-9222 **FAX:** 860-757-5991
Covering: AL, FL, GA, MD, MS, NC, SC, TN, VA, WV, District of Columbia



Sacramento: **Address:** 12009 Foundation Place, Rancho Cordova, CA 95670
Mailing Address: P.O. Box 13835, Sacramento, CA 95853-4827
Toll-Free: 866-401-9222 **FAX: 877-538-4262**
Covering: AK, CA, HI, OR, WA

Syracuse: **Address:** One Park Place, 300 South State Street, 7th Floor, Syracuse, NY 13202
Mailing Address: P.O. Box 4771, Syracuse, NY 13221
Toll-Free: 877-469-9222 **FAX: 877-536-3201**
Covering: CT, DE, MA, ME, NH, NJ, NY, PA, RI, VT

Workers' Compensation ClaimXchange Centers Information

For Medical Only Claim Handling

Aurora: For AL, AK*, CA, FL, GA, IA, IL, IN, KS, KY, MI, MN, MO,
MS, ND*, NE, OH, OR*, SC, SD, WA, WI:
Mailing Address: P.O. Box 7957, Wheaton, IL 60189-7957
Toll-Free: 800-762-0666

Syracuse: For AR, AZ*, CO, CT, DE, ID*, LA, MA, MD, ME, MT*, NC, NH, NJ, NM, NY,
NV, OK, PA, RI, SC, TN, TX, UT, VA, VT, WV, WY, District of Columbia:
Mailing Address: P.O. Box 4747, Syracuse, NY 13202
Toll-Free: 888-353-2304

For Medical Bill Submissions

For CA, FL, NJ, TX:
Mailing Address: P.O. Box 14187, Lexington, KY 40512
For billing inquiries: 800-662-5814 **FAX: 859-258-2239**

For All Other States:
Mailing Address: P.O. Box 14170, Lexington, KY 40512
For billing inquiries: 800-762-0666 **FAX: 859-258-2235**

Note: Nevada claims are handled by Specialty Risk Services, 750 E. Warm Springs Road, Suite 220,
P.O. Box 2, Las Vegas, NV 89119. Phone: 800-309-9142 FAX: 702-260-0824.

* Medical only claims for these designated states are handled in-state by adjusters reporting to
our Workers' Compensation Claim Centers.

Washington and Ohio medical only claims are handled by the State Boards.

Hawaii claims are handled in our Hawaii Claim Office, 1001 Bishop Street, Suite 1700,
Pauahi Tower, Honolulu, HI 96813. Phone: 808-546-5750 FAX: 808-538-0214.

Network Referral Unit



What is a Workers' Compensation medical network?

A medical network is an organization that has ready access to physicians, hospitals and other medical care providers who have experience treating workers' compensation related injuries. It also helps

you manage the cost associated with these injuries. The Hartford has contracted with medical networks across the United States to provide this service to our workers' compensation customers.

What is the Network Referral Unit?

The Hartford's Network Referral Unit (NRU) helps you identify the appropriate medical care providers in your area. The NRU will provide you with the immediate information by telephone or by mailing or faxing a list of providers. Please be sure to post the list where all employees will have access to it.

When should you contact the Network Referral Unit?

Now. Even before one of your employees is injured, we urge you to get a listing of approved medical providers in your area. In case of an injury, you will know who to call to get your employee immediate and appropriate medical attention.

How do you use the Network Referral Unit Services?

Call **1-800-327-3636**. You will need to provide the network referral analyst with a complete address of your work location so he/she can identify a medical provider. Employees also have the option to seek a referral where they live.

If you have questions regarding a specific claim or rules that govern use of network providers, contact your local Hartford claim office.

The Hartford's Network Referral Unit

Call 1-800-327-3636

**At the prompt PRESS 2
At the next prompt PRESS 4**

Monday through Friday
7 a.m. to 6 p.m. CST



The Hartford's Regional Medical Program Consultants

Best outcomes for your business...helping our customers manage claim costs through the use of preferred medical network providers and a national pharmacy program

Sharon Alicia	Southeast WC Claim Center 200 Colonial Ctr. Pkwy. Lake Mary, FL 32746	Phone: 877-673-9222 x23624 Fax: 860-757-5966 E-mail: sharon.alicia@thehartford.com Territory: AL, FL, GA, LA, MS, TN
Carol Doerge	Southwest WC Claim Center Northbelt II / Suite 210 785 Greens Parkway Houston, TX 77067-4409	Phone: 877-889-9222 x73874 Fax: 877-538-8966 E-mail: carol.doerge@thehartford.com Territory: AR, AZ, CO, ID, MT, NM, NV, OK, TX, UT, WY
Lisa Ferrandi	Baltimore WC Claim Office Shawan Center 200 International Circle Hunt Valley, MD 21030	Phone: 800-492-4794 x86549 Fax: 410-527-1337 E-mail: lisa.ferrandi@thehartford.com Territory: DC, MD, NC, SC, VA
Cynthia Smith	Northeast WC Claim Center One Park Place 300 South State Street-7th Flr. Syracuse, NY 13202	Phone: 877-469-9222 x 55167 Fax: 877-536-3201 E-mail: cynthia.smith@thehartford.com Territory: DE, NJ, NY, PA, WV
Robert Paterwic	Hartford WC Claim Office 55 Farmington Ave P.O. Box 2923 Hartford, CT 06104-2923	Phone: 877-469-9222 x 53516 Fax: 877-536-3201 E-Mail: robert.paterwic@thehartford.com Territory: CT, MA, ME, NH, RI, VT
Debra Robertson	Western WC Claim Center 12009 Foundation Place Rancho Cordova, CA 95670	Phone: 866-401-9222 x41499 Fax: 860-723-4251 E-mail: debra.robertson@thehartford.com Territory: AK, CA, HI, OR, WA
Jana Rouse	Central WC Claim Center 7300 West 110th Street Overland Park, KS 66210	Phone: 877- 952-9222 x38712 Fax: 913-693-8716 E-mail: jana.rouse@thehartford.com Territory: IA, IL, IN, KS, KY, MI, MN, MO, ND, NE, OH, SD, WI

RX Program

Best Outcomes For Your Business

Pharmaceutical expenses comprise a significant portion of workers' compensation costs. The Hartford offers TMESYS™, a pharmacy benefit management program (PBM) of Pharmacy Corporation of America to enable its customers to manage these costs while providing timely and efficient pharmaceutical services to their injured workers. Consider these benefits of The Hartford's PBM program:

The Hartford's Services Meet Customer Needs

- An automatic and simple process for injured workers that does not require a prescription ID card or claim/authorization forms.
- A payment process that is virtually transparent to the injured worker – meaning no out-of-pocket costs to the employee.

Pharmacy Capabilities

- Connection to TMESYS, with 24-hour access to our database of claimants.
- Online prescription review at point of service (prior to dispensing medications).
- Online claim eligibility verification.
- Electronic submission of claims to TMESYS.
- Around-the-clock customer support desk availability, 365 days per year.

Important Workers' Compensation Enhancements

- Retail pharmacy discounts.
- Permissible generic drug substitution (in place of more costly name brand medications).
- Point-of-service prescription review.

The voluntary program is simple to use. Employees inform their pharmacists that the prescriptions are for work-related injuries and supply their name and social security number.

Initial Prescriptions Filled Quickly through First Fill*

First Fill, a component of The Hartford's PBM, enables injured workers to obtain up to a 10-day supply of first prescriptions – before the claim has been established. Many work-related injuries occur outside the usual nine-to-five schedule and this program helps those injured workers fill prescriptions without delay. Through First Fill, employees avoid out-of-pocket costs for injury-related medications.

To qualify:

- The prescription must be written within 30 days from the date of injury.
- Medication must be included in The Hartford's formulary.
- A pharmacy within the TMESYS network must be used.

**First Fill is available in all states, except Delaware and Hawaii.*



The Hartford Injured Worker's Prescription Information Sheet

TAKE TO PHARMACY//LLEVAR A LA FARMACIA

Injured Worker Name: _____ Social Security #: _____ Date of Injury: _____

Dear Injured Worker,

We want you to be able to get your worker's compensation prescription drugs when you need them and at the pharmacy of your choice. Please give this notice to your pharmacy. The pharmacies listed below participate in the Tmesys pharmacy network and will expedite the processing of your approved Worker's Compensation prescriptions, based on the established parameters by The Hartford.

Apreciado Trabajador Lesionado,

Queremos que usted pueda obtener sus prescripciones de compensación de trabajador lesionado cuando las necesite y en la farmacia de su opción. Por favor, muestre este aviso en su farmacia. Las farmacias que aparecen en la siguiente lista participan en la red de farmacias de Tmesys, las cuales acelerarán el procesamiento de sus prescripciones aprobadas de compensación de trabajador lesionado, basadas en los parámetros establecidos por su compañía de seguros de compensación de trabajador lesionado, The Hartford.

Dear Pharmacist,

Please call the Tmesys™ Pharmacy Help Desk, 1-800-964-2531, to establish First Fill eligibility and obtain the ID# necessary for the online processing of Worker's Compensation medication for this newly injured worker. Please contact the Tmesys™ Pharmacy Help Desk and inform the Tmesys™ Help Desk Representative that there is a newly injured worker at your pharmacy filling a **Hartford** First Fill prescription.

Sincerely/Sinceramente,

Tmesys™, Inc.



ALL PARTICIPATING PHARMACIES HAVE NOT BEEN INCLUDED ON THIS LIST. PLEASE CALL The Hartford's Network Referral Unit at (800) 327-3636/ prompt 4 TO OBTAIN A LISTING OF OTHER PARTICIPATING PHARMACIES IN YOUR AREA.

CHAIN NAME	INDEX NAME	CHAIN NAME	INDEX NAME	CHAIN NAME	INDEX NAME	CHAIN NAME	INDEX NAME
A & P	index: TYS	Giant Pharmacy	TMESYS	Milex Drugs	code: Satan	Shop-Rite	TYS
Arbor Drug	Carrier code: TI	Goodings	TME index D, bill code TME	Milner-Rushing Drugs	compensation as Tom Ashley	Stop N Shop	146
Bartell Drug	Index: TMS	Hannaford Food & Drug	index: TYS	National Supermarkets	use "Separate Plan Number"	Super D	Plan name:332
Big B	index: TYS	Happy Harry's	index:TME	NOB Hill Phcy	plan: TMESYS	Super Valu	carrier code: TYS
Biggs	Carrier code: TYS	Harco Phcy	index: TYS	Pathmark Pharmacy	TYS	Super X (HSI)	index: TME
Bi-Lo Pharmacy	input code: TMS	Hi-School Pharmacy	TMESYS Central Billing code:TM01	Perry Drg Str	index:TS	Thrift Drug	carrier code: 4139
Bi-Mart	index: TMESYS	HEB Phcy	price code:T9	Phar-Mor	TYS	Thriftway Pharmacy	2066
Brooks Drugs	Code: TME	Hooks, Brooks& Super X(HIS)	index: TME	Pic & Save	plan name: T or TMESYS	Tom Thumb Phcy	pdx code: TMS
Brookshire Brothers	Condor Code: 2050	Horizon Pharmacy	TYS	Prevo Drugs	input code: TS	Tops Pharmacy	access code: TI
Cardinal Health	index: Call support	HyVee Drugtown	index:bin # in 3rd party set up	Publix	carrier:TME plan: SYS or TYS	Tri Daly Drugs	Carrier code: TMS
Cub Pharmacy	Carrier Code: TYS	J & J Pharmacy	TCS	Raley's/Bel Air Phcy	plan: Tmesys	Turner Drugs	Index: Tmesys
CVS Drugs	Condor Code: 8822	Joel & Jerry's	index: TME	Randalls Pharmacy	TMSRX	Twin Value	carrier code:TYS
Drug Emporium	TYS	K & B	Plan code:TMESYS	Revco drugs	TMWC	U-Save	index: TME
Drug Fair	index: TMESYS	Kash N Karry	plan: TYS	Rite-Aid drugs	TMESYS	United	TYS
Duane Reade	TMESYS	Kerr Drugs	TMESYS	RX Discount Pharmacy	input code:TME	Vons	carrier: TME
Eckerds(FL)	Termimal plan:2802(FL)	K-mart phcy	Carrier code: TYS	Sack-n-Save	plan#: 6012 or 5097	VIX Pharmcay	carrier code: TME
Eckerds(all others)	Termimal plan:2801	Kroger Phcy	index: TS, TM,YS	Safeway Phcy	processor code: TME or TYS	Walgreens	carrier code: TMEWC
Franck's Pharmacy	price code: TM	Laverdiere's	plan name: TMESYS	Sav-A-Lot	60	Wal-Mart phcy	carrier: TME
Fred Meyer	TYS	Lifecheck Drug	TMESYS	Sams Club Pharmacy	carrier code: TME	Wegman Pharmacy	carrier code: TME
Fred's Pharmacy	TMESYS	Long's Phcy	plan: #1,TMES	Save Mart	Carrier code: TYS	Weis Markets	carrier code: TYS
Genovese	Now Eckerd Drugs!	Medicine Shoppe	varies by each store system	Shopko Pharmacy	TYS	Winn-Dixie	index: TME (plan 2066)
Giant Eagle Pharmacy	index:TME (Do not use WC plan	Medistat Phcy	Condor code: 2425	Shop N Save	carrier code: TYS		

Employer Name: _____

A Team Effort

Injured worker, employer, medical provider and The Hartford claim staff - we all share the common goal of helping the injured worker recover and return to work as soon as medically appropriate. Each of us plays a critical role in the return to work process, and working as a team, we make it easier for an injured employee to get back to work safely and quickly.

Team•Work is a team approach to return to work designed to facilitate an injured employee's safe return to the workplace. At The Hartford, we believe in ability management, focusing on what an injured employee *can do* instead of what they can't do.

Ability management is about possibilities, and that is the key to helping an injured worker recover. We have learned that helping an injured worker return to occupational activities appropriate for his or her ability is therapeutic and contributes positively to the employee's ultimate recovery.

With Team•Work, our claim handlers, nurse case managers, loss control experts and vocational rehabilitation specialists work as a team with the injured worker, employer and medical provider to find transitional employment opportunities that meet the worker's capabilities. By working together, we can assist the injured worker in resuming his or her pre-injury way of life as quickly as possible.

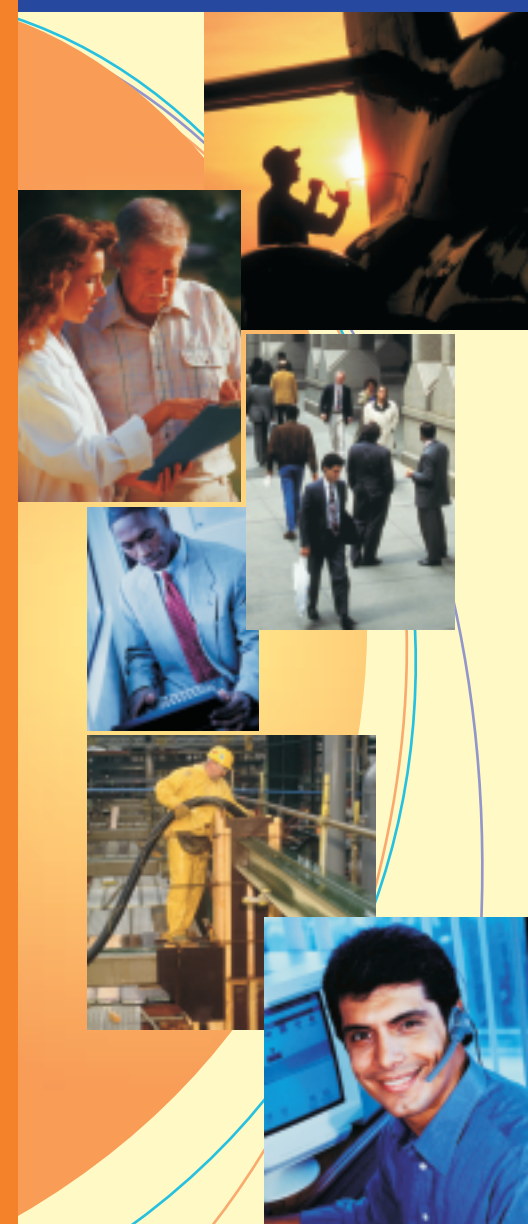
The Hartford's

SM



The Hartford's
TEAM•WORKSM

A Team Approach for Return To Work



We strive to return every injured employee to gainful employment in the same job or a different position based on his or her unique situation.

---EMPLOYEE---

If you have been injured at work

Once we are notified of your injury, we contact you and your employer to learn the details of your injury and how you are recovering. We collaborate with you, your employer and medical provider to find ways to bring you back to work and normal activities as soon as medically possible.

To help you throughout the process, your claim handler or nurse case manager will:

- Explain what to expect from us and will answer any questions you may have.
- Talk to you about how we can help get you back to work and when you may anticipate resuming your job duties.
- Work with your employer to assist you in returning to work as soon as medically appropriate.
- Contact you periodically about your recovery and when you expect to return to work.

In some cases, you may be assigned a nurse case manager who will coordinate with your medical provider and your employer to help you transition back into the workplace.

A workplace injury does not mean an employee cannot work. He or she may be able to perform functions other than his or her current job. We work closely with you to facilitate a smooth return to work transition for your employee and your company.

---EMPLOYER---

If your employee has been injured at work

If your employee is unable to resume full duty, we collaborate with you to provide suitable transitional employment such as part-time work or temporarily assuming other duties.

You can assist your employee's early return to work in several ways:

- Keep in contact with your employee.
- Work with us to consider all options for returning the employee to work.
- Complete and return our Physical Demands Analysis form to help us understand the physical requirements of the worker's job and assist us in finding alternatives if the employee is not able to manage those requirements due to the injury.

As an employer, you can help workers return to work quickly, and that leads to faster recovery and better results for everyone.

Medical providers are a key source of information in a successful return-to-work program. We work with you to explore all options to help the injured worker resume meaningful employment as soon as medically appropriate.

---MEDICAL PROVIDER---

If you are providing medical treatment for a work-related injury

As a medical provider, you assist the employee's return to work in several ways:

- Identify the injured worker's abilities and work with us to recommend options for returning the employee to the workplace.
- Provide input on our proposed transitional employment alternatives for the injured worker.
- Complete and return the Physical Capabilities Evaluation form to provide necessary medical information.*
- Review the Physical Demands Analysis form to determine which job functions, if any, need to be restricted. This information is also shared with physical therapists in order to understand the rehabilitation required for the employee's job.*

Working together, we can find creative ways to help the employee safely return to productive work.

*Employee's consent is required before information is shared.

Physical Demands Analysis



Employee _____ Employer _____

Claim Number _____ Job Title _____ Date of Injury _____

I. Employee works how many hours per day? _____ How many days per week? _____

How many hours per day is the employee required to: Sit ___ ; Stand ___; Walk___; Drive _____

II. How often during the work day does the employee have to Lift/Carry,

	<u>Never</u>	<u>Occasionally</u> (0-33%) 1-3 Hr	<u>Frequently</u> (34-66%) 4-6 Hr	<u>Constantly</u> (67-100%) 6-8 Hr
1 – 10 lbs.	_____	_____	_____	_____
11 – 20 lbs.	_____	_____	_____	_____
21 – 50 lbs.	_____	_____	_____	_____
51 – 100 lbs.	_____	_____	_____	_____
over 100 lbs.	_____	_____	_____	_____

III. How often during the work day does the employee have to Push/Pull

	<u>Never</u>	<u>Occasionally</u> (0-33%) 1-3 Hr	<u>Frequently</u> (34-66%) 4-6Hr	<u>Constantly</u> (67-100%) 6-8Hr
1 – 10 lbs.	_____	_____	_____	_____
11 – 20 lbs.	_____	_____	_____	_____
21 – 50 lbs.	_____	_____	_____	_____
51 – 100 lbs.	_____	_____	_____	_____
over 100 lbs.	_____	_____	_____	_____

IV. How often must the employee perform the following? (N=Never, O=Occas, F=Freq, C=Const)

Climbing _____	Crouching _____	Grasping _____
Balancing _____	Crawling _____	Overhead lifting _____
Bending _____	Reaching _____	Work on ladders _____
Stooping _____	Handling _____	Feeling _____
Kneeling _____	Fine Manipulation _____	Keying _____

V. Is repetitive use of the feet required? Right: ___ yes/ no ___; Left: ___ yes/no ___

Is repetitive use of the hands required? Right: ___ yes/ no ___; Left: ___ yes/no ___

VI. Does the employee work in any environmental conditions which may be a problem (e.g., temperature extremes, hazards, moving machinery, etc.)?

If so, please list them: _____

VII. Are you able to accommodate transitional duty? yes/ no Part time work? yes/no

If yes, what does it involve? _____

Signed: _____ Title: _____ Date: _____

Please fax completed form to Attn: _____ Fax: _____

Thank You

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THE HARTFORD

FAX

Date

Number of pages including cover sheet

<i>To</i>	
<i>Phone</i>	
<i>Fax Phone</i>	
<i>Employee</i>	
<i>Claim #</i>	
<i>Date of Injury</i>	
<i>Date of Birth</i>	

<i>From</i>	
<i>Address</i>	
<i>Phone</i>	
<i>Fax Phone</i>	

CC: _____

REMARKS: *Urgent* *For your review* *Reply ASAP* *Please Comment*

Attached is a form addressing this injured worker's **regular job duties**. Please complete this form specifying the physical demands of his/her job. This information will then be presented to the injured worker's treating physician to help coordinate an early and safe return to work. Please be sure to indicate if transitional duty is available.

We will keep you informed of the progress of your employee. If you have any questions regarding this form please contact me at the above number.

Thank you for your cooperation.

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Physical Capabilities Evaluation



Employee _____ Employer _____

Claim Number _____ Job Title _____ Date of Injury _____

I. How many hours can the patient work per day? _____ How many days per week? _____

How many hours per day is the patient able to: Sit _____; Stand _____; Walk _____; Drive _____

II. How often during the work day is the patient able to Lift/Carry:

	<u>Never</u>	<u>Occasionally</u> (0-33%) 1-3 Hr	<u>Frequently</u> (34-66%) 4-6 Hr	<u>Constantly</u> (67-100%) 6-8 Hr
1 – 10 lbs.	_____	_____	_____	_____
11 – 20 lbs.	_____	_____	_____	_____
21 – 50 lbs.	_____	_____	_____	_____
51 – 100 lbs.	_____	_____	_____	_____
over 100 lbs.	_____	_____	_____	_____

III. How often during the work day is the patient able to Push/Pull:

	<u>Never</u>	<u>Occasionally</u> (0-33%) 1-3 Hr	<u>Frequently</u> (34-66%) 4-6Hr	<u>Constantly</u> (67-100%) 6-8Hr
1 – 10 lbs.	_____	_____	_____	_____
11 – 20 lbs.	_____	_____	_____	_____
21 – 50 lbs.	_____	_____	_____	_____
51 – 100 lbs.	_____	_____	_____	_____
over 100 lbs.	_____	_____	_____	_____

IV. How often during the workday may the patient perform the following? (N=Never, O=Occas, F=Freq, C=Const)

Climbing _____	Crouching _____	Grasping _____
Balancing _____	Crawling _____	Overhead lifting _____
Bending _____	Reaching _____	Work on ladders _____
Stooping _____	Handling _____	Feeling _____
Kneeling _____	Fine Manipulation _____	Keying _____

V. Can the patient use his/her feet repetitively? Right: _____ yes/ no _____; Left: _____ yes/no _____

Can the patient use his/her hands repetitively? Right: _____ yes/ no _____; Left: _____ yes/no _____

VI. Does the patient have any additional restrictions of an environmental nature (e.g., temperature extremes, hazards, moving machinery, etc.)?

If so, please list them: _____

VII. Has the patient reached maximum medical improvement: _____ yes/ no _____; If Yes, Rating _____

Date patient can return to work at his/her regular occupation: _____

Date patient can return to work in a transitional duty capacity: _____

If so, please provide any additional restrictions: _____

Signed: _____ Print Name: _____ Date: _____

Please fax completed form to Attn: _____ Fax: _____

Thank you

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THE HARTFORD



FAX

Date _____

Number of pages including cover sheet _____

To:	_____
Phone	_____
Fax Phone	_____
Employee	_____
Claim #	_____
Date of Injury	_____
Date of Birth	_____

From	_____
Address	_____

Phone	_____
Fax Phone	_____

CC: _____

REMARKS: Urgent For your review Reply ASAP Please Comment

Dear Dr.

Please see the attached forms.

The Physical Demands Analysis form has been completed by the employer and describes the injured employee's regular job duties.

The Physical Capabilities Evaluation form is for your completion. Please identify the injured employee's current work ability.

When completed, please sign and fax to me at the above number.

Thank you for your assistance.

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