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CGS EAST | CGS SOUTHEAST | CGS WEST

Address: 14269 N. 87th Street, Suite 201
Scottsdale, AZ 85260
Phone: (480) 219-9795
Fax: (480) 219-9709
Email: **safety@cgsglobal.com**

INCIDENT REPORTING PROCEDURES FOR WORKERS' COMPENSATION

IF INJURY REQUIRES EMERGENCY RESPONSE, CALL 911 & NOTIFY HR.
***** All forms should be completed and emailed to safety@cgsglobal.com *****
Any Questions - Please Call Toll Free – (833) CGS-CORP ((833) 247-2677)
All injuries must be reported as soon as possible. *Claims reported after 24 hours increase costs by 40%, **including your deductibles***
GIVE THE LAST 2 PAGES OF THIS PACKET TO THE INJURED EMPLOYEE BEFORE GOING TO MEDICAL FACILITY TO ASSIST WITH BILLING AND MEDICATION

1. Does the employee require medical treatment?

1.1. YES, Medical Treatment Is Needed:

	Call Medcor Triage Services (800) 775-5866 - - Acct # WC-2773625-00	
	✓ Send or take employee to the approved doctor/facility provided by Triage Nurse, or to nearest Care Facility (such as Concentra, AIM Clinic, Banner Urgent Care, Etc.).	
	✓ Have employee(s) complete and sign the Employee Incident Report.	Pg. 3
	✓ Have all witnesses (if any) complete and sign a Witness Statement.	Pg. 4
	✓ Have supervisor complete and sign the Supervisors Statement.	Pg. 5
	✓ Have employee read and sign the Light Duty Work Assignment Form.	Pg. 6

1.2. NO, Medical Treatment Is Not Needed:

	✓ Have employee sign the Refusal of Doctor's Care Agreement	Pg. 2
	✓ Have all witnesses (if any) complete and sign a Witness Statement.	Pg. 3
	✓ Have supervisor complete and sign the Supervisors Statement.	Pg. 4
	✓ Have employee read and sign the Light Duty Work Assignment Form.	Pg. 5

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REFUSAL OF DOCTORS CARE

DUE: AS SOON AS POSSIBLE, not to exceed 24 HOURS

I, _____, have reported a job related injury on _____.

Employee Name: _____ Injury Date: _____

I have explained the details of this incident to my supervisor, and hereby acknowledge my refusal of medical treatment and/or observation offered to me at the expense of CGS Arizona for the work-related injury I incurred.

I acknowledge that my supervisor(s), in good faith, have offered and made available to me an opportunity to seek necessary medical treatment and/or observation. I am aware that by declining medical treatment at this time -- my employer -- will not be responsible for any medical expenses or lost wages.

I understand that by signing this statement, I am not giving up my right to seek medical treatment in the future, if I feel it is necessary. I further understand that if I do not follow the procedures as reflected in my employment agreement, my injury may not be covered by Workers' Compensation.

I understand that state law allows an employer to require a drug screen within twenty-four hours of an injury report, and by not complying with that law, I may not be covered by Workers' Compensation for this injury.

Understood and agreed on,		(mm/dd/yyyy)

Employee Signature	
SSN #	
Date of Injury: (mm/dd/yyyy)	

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EMPLOYEE INCIDENT REPORT

****REPORT DUE WITHIN 24 HOURS OF ACCIDENT****

Complete ALL Information

Date of this Report:		Name of Injured Worker:	
Date of Incident:		SSN #:	
Time of Incident:		Birthdate:	
Date Employee Reported Incident:		Phone:	
Person Employee Reported Incident To:		Home Address:	
Time Employee Reported for Workday of Incident:		City, State & Zip:	
Jobsite Incident Occurred:		Marital Status:	
Address Where Incident Occurred:		Number of Dependents:	
Type of Injury (cut, sprain, bruise, fracture, etc.):		Weekly (or Hourly) Wages:	
Which part of body injured (be specific):		List all witnesses to this incident:	
Describe the incident in detail (how, why, where, what):			
Are there any safety issues that contributed to this injury? If so, please detail:			
List all prior injuries sustained at work and outside of work in the last 10 years that required medical attention (include dates, injuries, and body parts):			

I, employee, the undersigned, certify that the above is a true and correct statement of fact and that I made such statements of free will. I understand that any payments to me or anyone else for expenses in connection with my accident and resulting injury is not an admission of liability on the part of my employer and/or the Insurance Company. I authorize full access to copies of medical records, radiology reports, drug/alcohol screenings, and documents of any kind relating to my past or present injury/illness to my employer. I hereby agree to release this information and hold all such medical providers harmless for the release of this information as set forth in this authorization. "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

Employee Signature	*Date of Report*	*Translated by (if applicable)*
CGS will prosecute to the fullest jurisdictional extent for all fraudulent claims reported. Per employment policy, a drug test is mandatory on all reported claims.		

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WITNESS STATEMENT

****REPORT DUE WITHIN 24 HOURS OF ACCIDENT****

Complete ALL Information

Injured Worker's Name		Jobsite where injury occurred:	
Name of Witness:		Date of this report:	
Witness Phone #:		Date of Incident:	
Witness's Employer:		Time of Incident:	

Are you related to the injured worker? (circle one)	Yes	No
How long have you known the injured worker?		
Did you actually see the incident?		
Explain, in detail, what you saw or know regarding this incident:		
List the names of any other persons who may have information regarding this incident:		
Is there any other information that you know that would assist in providing a fair evaluation of this incident?		

Print Name:		Signature:	
Phone:		Date Signed:	
By signing this form, you acknowledge your understanding that any person who knowingly submits false or fraudulent information is guilty of a crime and may be subject to fines and/or confinement in state prison.			

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SUPERVISOR STATEMENT

****REPORT DUE WITHIN 24 HOURS OF ACCIDENT****

Complete ALL Information

Injured Worker's Name		Jobsite where injury occurred:	
Name of Supervisor:		Date of this report:	
Supervisor's Phone #:		Date of Incident:	
Supervisor's Employer:		Time of Incident:	

Address Where Incident Occurred:	
What directly injured the worker:	
What kind of injury - (cut, sprain, bruise, fracture, etc.):	
What body part was injured:	
Where did the worker go for treatment (Or was First Aid given):	
Explain, in detail, what you saw or know regarding this incident:	
List the names of any other persons who may have information regarding this incident:	
Is there any other information that you know that would assist in providing a fair evaluation of this incident:	
How do you think this accident could have been prevented:	

Print Name:		Signature:	
Phone:		Date Signed:	

By signing this form, you acknowledge your understanding that any person who knowingly submits false or fraudulent information is guilty of a crime and may be subject to fines and/or confinement in state prison.

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LIGHT DUTY WORK ASSIGNMENTS

When you are on a Light Duty assignment in the office you will be expected to:

1. Adhere to your doctors prescribed work restrictions.
2. Report to your assigned workstation, or location, on time.
3. Do the work that is expected of you for the assignment you have received. You will be supervised or tested as to your performance.
4. Take breaks and lunch only when you are assigned to do so.
5. Return from break and lunch on time.

When you are on a Light Duty assignment in the office you will <u>NOT</u> be allowed to:

1. Abandon your doctors prescribed work restrictions.
2. Take extra breaks (Unless you have a doctor's note to permit such).
3. Walk through the office or premises to talk with other workers.
4. Sit in the break room and talk, unless during scheduled breaks.

While on a Light Duty assignment, all policies and procedures of this company are in effect and will be implemented. If you do not follow these policies and procedures, as you would under normal working conditions, you will be subject to disciplinary action.

I have read the above policy, and my Light Duty assignment as noted above. I was given the opportunity to ask questions about anything that was not clear to me. I have been offered this work to accommodate my restrictions. I also understand and accept as part of my employment that this is the policy of my employer.

Print Name		☐	Accept – this job offer	☐	Decline – this job offer

Employee Signature:		Date	

Required for Employees Injured in California Only

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 in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

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. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

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.

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. ☐ Check if you agree to receive notices about your claim by email only. ☐ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____.

You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*

9. Signature of employee. *Firma del empleado.* _____

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

10. Name of employer. *Nombre del empleador.* _____
11. Address. *Dirección.* _____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
16. Insurance Policy Number. *El número de la póliza de Seguro.* _____
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. 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*

Rev. 1/1/2016

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ENTREGUE ESTA HOJA Y LA SIGUIENTE AL EMPLEADO LESIONADO ANTES DE IR AL CENTRO MEDICO PARA AYDAR CON LA FACTURACION Y LA MEDICACION

AUTHORIZATION FOR MEDICAL TREATMENT FOR WORKERS' COMPENSATION

Provider: Zurich North America/CBCS/Industrial Staffing, Ltd.

Policy Holder: CGS

Policy #: WC 2773625-00

Employee Name:	
Date of Injury:	
Type of Injury:	
Perform a drug & alcohol screening:	**YES**
Mail Bill To:	CBCS
	P.O. Box 28
	Dunuque, IA 52004-0028
	Toll Free: 1-877-241-6121
	Fax: 1-563-587-5804
Or Email Bill To:	adriscoll@cbcsclaims.com

Supervisor Signature:		Date:	

OPTUM®

PO Box 152539
Tampa, FL 33684-2539

CBCS
A BETTER CLAIMS EXPERIENCE

MAKING IT EASY TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured person:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. In most cases, the pharmacy will fill the prescription at no cost to you.

If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Employer:

Immediately upon receiving notice of injury, fill in the information below and give this form to the employee.

Finding a network pharmacy

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM® CBCS

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Zurich NA/ CBCS — CARRIER/TPA

CGS — EMPLOYER

INJURED PERSON NAME

Please provide directly to Pharmacist — SOCIAL SECURITY NUMBER

DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	CABCFF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

tmesys®

IMP14-2013-11