POST-ACCIDENT
WORKERS' COMPENSATION PACKET

This packet contains important forms and documents required for proper workers' compensation claims management.

QUESTIONS? CONTACT PROSERVICE HAWAII CLAIMS DEPARTMENT AT 808-725-6955.

ACCIDENT REPORTING POLICY

When a work-related accident occurs:

1. Employee(s) must report any and all accidents to their supervisors immediately.

2. If the injury requires professional medical attention, a supervisor or a company representative should, whenever possible, accompany the injured worker to the medical care facility (see recommended provider listing) to ensure employee safety.

3. ProService requires verbal notification **within 24 hours** of the accident. If your call is placed after work hours or on a weekend or holiday, please leave a detailed voicemail message.

   TOLL-FREE PHONE: 888-892-8878
   OAHU: 808-725-6955

4. ProService has a **post-accident drug testing policy**. The drug test will be scheduled by ProService.

   The injured employee(s), as well as any other employees involved in the accident, may be required to take a drug test within 24 hours of notification, if not the same day of the accident. Client will cooperate fully with ProService in the administration of this post-accident drug testing policy, and consider any disciplinary action recommended by ProService with respect to any tested employee who provided a positive finding.

5. An *Accident Report Form* must be completed and submitted as soon as possible immediately following the accident. ProService must receive this completed form **within 48 hours** of occurrence. Any questions left unanswered will delay the claims process. Fax or email the completed form to:

   TOLL-FREE FAX: 888-783-8333
   OAHU FAX: 808-394-3140
   EMAIL: wc_claims@proservice.com

6. A ProService Risk Control Consultant may contact you to discuss the accident and provide recommendations for corrective measures in order to prevent future injuries.

7. A claims adjuster will contact the worksite supervisor, the injured employee(s) and any witnesses to discuss the accident in further detail.

POST THE FOLLOWING ACCIDENT REPORTING FLYER IN A CONSPICUOUS, CENTRAL LOCATION THAT IS VISIBLE TO ALL EMPLOYEES.

*** PLEASE POST IN A CENTRAL LOCATION VISIBLE TO ALL EMPLOYEES ***

ACCIDENT REPORTING PROCEDURES

When a work-related accident occurs:

1. **Report any and all accidents to your supervisor immediately.**

2. **If the injury requires professional medical attention, a supervisor or a company representative should, whenever possible, accompany the injured worker to the medical care facility to ensure employee safety and that the drug and alcohol screening is administered.**

3. **ProService requires verbal notification WITHIN 24 HOURS of the accident. Please call:**

   ProService Hawaii Claims Department
   808-725-6955

4. **ProService has a post-accident drug testing policy. Drug test will be scheduled by ProService.**

   The injured employee(s), as well as any other employee(s) involved in the accident, may be required to take a drug test within 24 hours of notification, if not the same day of the accident.

5. **An *Accident Report Form* must be completed and submitted to ProService as soon as possible immediately following the accident. ProService must receive this completed form WITHIN 48 HOURS of occurrence. Fax or email the completed form to:**

   ProService Hawaii Claims Department
   Fax: 808-394-3140 Email: wc_claims@proservice.com

6. **A claims adjuster will be in contact with the supervisor, the injured employee(s) and any witnesses to discuss the accident in further detail.**

WORKERS' COMPENSATION

LIST OF PREFERRED PROVIDERS

These medical facilities, sorted by island, are our preferred providers of medical services for work-related injuries. Our workers' compensation claims administrator maintains a positive and close working relationship with these top facilities. Therefore, ProService employees receive preferred access and services from these providers.

PREFERRED PROVIDERS – OAHU

Kaiser Occupational Health Services

Honolulu Clinic 1010 Pensacola St, 2nd Floor Honolulu, HI 96814 Phone: 432-2200	Moanalua Medical Center (Emergency Only) 3288 Moanalua Rd. Honolulu, HI 96819 Phone: 432-2208	Waipio Clinic 94-1480 Moaniani St. Waipahu, HI 96797 Phone: 432-3103

Urgent Care Hawaii (***Unable to see patients if it has been more than one week from date of injury)***

Pearl City 1245 Kuala St., Suite 103 Pearl City, HI 96782 Phone: 808-784-2273	Kapolei 890 Kamokila Blvd. Kapolei, HI 96707 Phone: 808-521-2273	Kailua 660 Kailua Rd. Kailua, HI 96734 Phone: 808-263-2273	Waikiki 1860 Ala Moana Blvd., #101 Honolulu, HI 96815 Phone: 808-927-2273

Concentra Medical Centers	**The Medical Corner**	**Orthopedic Services Company**
Airport Clinic 545 Ohohia St. Honolulu, HI 96819 Phone: 831-3000	Airport Clinic 550 Paiea St. Honolulu, HI 96819 Phone: 954-4500	The Queen's Physicians' Office Building I 1380 Lusitana St. #608 Honolulu, HI 96813-2492 Phone: 536-2261

PREFERRED PROVIDERS – MAUI

Kaiser Occupational Health Services

Wailuku Clinic OHS 80 Mahalani St. Wailuku, HI 96793 Phone: 808-243-6453	Lahaina Clinic 910 Wainee St. Lahaina, HI 96761 Phone: 808-662-6900

PREFERRED PROVIDERS – KAUAI

Kauai Medical Clinic
3-3420 B Kukio Hwy.
Lihue, HI 96766
Phone: 808-245-1500

ProService HAWAII

PHYSICAL CAPABILITIES EVALUATION

This form must be completed by the attending physician during the injured employee's office visit following a work-related accident.

Date:	Date of Injury:
Patient/Employee Name:	Claim Number:
Date of Office Visit:	Date of Next Office Visit:

I. RETURN-TO-WORK STATEMENT:

a. Will allow the employee to return-to-work as of_____ (date) **without** restrictions (Full Capacity).

b. Will allow the employee to return-to-work as of_____(date) **with** the restrictions noted in Part II, until _____.

II. RESTRICTIONS: In an 8-hour workday, employee can (circle or check appropriate/No Restrictions for each)

Sit	1	2	3	4	5	6	7	8	Hrs. Per Day
Stand	1	2	3	4	5	6	7	8	Hrs. Per Day
Walk	1	2	3	4	5	6	7	8	Hrs. Per Day

ACTIVITY	NOT AT ALL	OCCASIONALLY	FREQUENTLY	NO RESTRICTIONS
Bend				
Climb				
Crawl/Kneel				
Squat				
Reach				
Twist				
Operate Car/Truck				
Heavy Equipment				
Lift/Carry 5-10 lbs.				
Lift/Carry 15-20 lbs.				
Lift/Carry 25-30 lbs.				

USE OF HAND/WRIST/ARMS			
Simple Grasping	Left	Right	Both (No Restrictions)
Fine Manipulation	Left	Right	Both (No Restrictions)
Keyboard Entry	Left	Right	Both (No Restrictions)
Pushing & Pulling	Left	Right	Both (No Restrictions)
Overhead Work	Left	Right	Both (No Restrictions)
USE OF LEGS/FEET			
Foot Controls/Pedal	Left	Right	Both (No Restrictions)

☐ **EMPLOYEE IS UNABLE TO WORK AT ALL** **ESTIMATED FULL-DUTY RELEASE DATE/TIME-FRAME** _____

If you are not releasing the injured employee to perform any type of light-duty work, please provide a detailed medical explanation for your diagnosis, along with an estimated date/time-frame you anticipate releasing the employee to some form of light-duty work.

_____

_____

_____

PLEASE ATTACH SUPPORTING OFFICE VISIT NOTES AND/OR TREATMENT PLANS, AS NEEDED

PHYSICIAN SIGNATURE: _____ DATE: _____

Fax completed form to ProService Hawaii at: 808-394-3140

6600 Kalanianaole Hwy. Suite 300, Honolulu, HI 96825

EQUIAN RX
FIRST FILL INFORMATION SHEET

Equian administers worker's compensation pharmacy benefits on behalf of ProService Hawaii. Please find information below to fill the injured worker's initial prescribed medication.

PATIENT INFO

Take this information sheet along with your prescriptions to any one of the participating pharmacies in our network. Your prescriptions will be filled with generic drugs unless otherwise indicated by your physician. If you choose to receive brand name drugs when a generic is authorized, you will be responsible for the difference in cost. You will only receive your initial prescribed medication up to a 7-day supply.

LOCATING A PHARMACY

You may fill your prescriptions at any pharmacy in our network. This network includes many smaller independent pharmacies as well as most of the chain pharmacies such as Walgreens, Longs Pharmacy, Costco Pharmacy, and many others. If you have trouble finding a local pharmacy in the network, please call 866-895-2021.

NOTICE TO PHARMACISTS:

This First Fill Information Sheet is to be used on a one-time basis and expires 24 hours from its initial use for the initial medications only. ***Medications will be filled with a maximum of a 7-day supply.*** All manual submissions or submissions from other billing sources will be rejected by Equian Rx.

NOTICE TO PATIENT:

This information is to be used on a temporary (one use) basis only and is not a guarantee of benefits. When your plan is notified that you have used the first fill and accepts your claim, we will send you a permanent card for use with all future prescriptions that are related to your claim.

Any unauthorized or fraudulent use to obtain prescription drugs is punishable by law.

For all processing questions, including blocked transactions, please call 866-895-2021.

RxBIN: 010553

PCN: **ALS**

RxGroup: BMFF2208

ID:

(Injured Worker's SSN and date of injury)
Example: nnnnnnnnnmmddyy

7 DAY SUPPLY LIMIT
FIRST FILL TERMINATES 24 HRS AFTER INITIAL USE

No Person Code used.

The eligibility of benefits under this information is determined solely by the online system. All manual submissions or submissions from other billing sources will be rejected by Equian Rx.

Mandatory generic substitution unless otherwise noted by physician.

ACCIDENT REPORT FORM

✓ **ProService requires verbal notification within 24 hours of the accident; call 808-725-6955.**
✓ **Fax or email this completed form to ProService Claims Department at 808-394-3140 or wc_claims@proservice.com as soon as possible immediately following any work-related accident; must be within 48 hours of occurrence.**
✓ **A post-accident drug testing may be required following any work-related accident.**

COMPLETED BY THE EMPLOYEE'S SUPERVISOR

Company name:

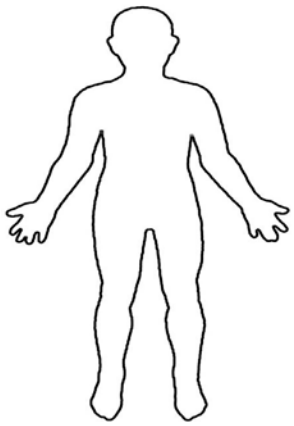
Injured person's name: Last First MI

Home address: City State Zip code

Home telephone number:	Work telephone number:	Cellular telephone number:
Social security number:	Date of birth:	Job title and department:
Date and time of accident / injury:	Location of accident / injury:	Date and time reported:

Name of immediate supervisor: Phone number of immediate supervisor:

Circle injured body part:



Specific body part(s) injured:

- ☐ right ☐ left EYE
- ☐ right ☐ left ARM
- ☐ right ☐ left HAND
- ☐ right ☐ left FINGER, which one:
- ☐ right ☐ left LEG
- ☐ right ☐ left FOOT
- ☐ right ☐ left TOE, which one:
- ☐ upper ☐ lower BACK
- ☐ HEAD ☐ NECK
- ☐ CHEST
- ☐ ABDOMEN
- ☐ RESPIRATORY

Type of injury

- ☐ Abrasion
- ☐ Amputation
- ☐ Burn
- ☐ Concussion
- ☐ Contusion
- ☐ Foreign body object
- ☐ Hernia
- ☐ Laceration
- ☐ Puncture
- ☐ Strain / sprain
- ☐ Other:

Was first aid required? ☐ Yes ☐ No	Was outside medical treatment needed? ☐ Yes ☐ No If "yes" provide medical facility and/or doctor's name:	Is a follow-up doctor visit required? ☐ Ye ☐ No

Is lost time expected? ☐ Yes ☐ No	Was personal protective equipment required? ☐ Yes ☐ No	Was personal protective equipment used? ☐ Yes ☐ No

Description of accident / injury:

What (if any) unsafe acts or conditions contributed to the accident / injury?
What actions will be taken to prevent such unsafe acts or conditions in the future?

Was the accident / injury caused by someone who is not on ProService's payroll? ☐ Yes ☐ No
If "yes" provide their name and phone number:

Were there any witnesses to the accident / injury? ☐ Yes ☐ No If "yes"
witness must complete WITNESS STATEMENT section on pg 2.

Supervisor signature:

Print name:	Date:

ACTIONS PRECEDING THE INCIDENT
COMPLETED BY THE EMPLOYEE

Please describe, in detail, the event(s) that resulted in the accident/injury. What, if anything, contributed to the accident/injury?
What were you doing at the time of the accident/injury?
What object or substance caused the actual injury?
What time did your shift begin?

Employee signature:	Date:

WITNESS STATEMENT
(Attach additional pages for multiple witness statements.)

Witness name: Last	First	MI	
Home address:	City	State	Zip code

Home telephone number:	Work telephone number:	Cellular telephone number:
Statement:		

Witness signature:	Date:

FAX OR EMAIL COMPLETED ACCIDENT REPORT FORM TO *CLAIMS DEPARTMENT* AT 808-394-3140 OR WC_CLAIMS@PROSERVICE.COM AS SOON AS POSSIBLE IMMEDIATELY FOLLOWING ANY WORK-RELATED ACCIDENT.

SAFETY WARNING

Company:	
Name of Employee:	
Employee's occupation:	Number of years in occupation:
☐ 1st Warning ☐ 2nd Warning ☐ 3rd Warning	
Incident Information	
Date and time of incident / violation:	Location:
Description of incident / violation:	
Witness(es) to incident / violation:	
Was this incident in violation of a company policy? If yes, specify which policy: ☐ Yes ☐ No	
Corrective Action	
Corrective actions recommended:	
Corrective actions taken:	Date:
Signature of person preparing report:	Date:

NOTE: This safety form is provided as a resource only, intended to assist the user to better identify potential site hazards. This document may not include every possible potential hazard on site. It is up to the user to ensure that all potential hazards are identified and abated. ProService Hawaii assumes no responsibility for the control or correction of conditions noted in this document. This safety form is part of the service encompassed by your Services Agreement with ProService.

QUESTIONS? CONTACT PROSERVICE HAWAII CLAIMS DEPARTMENT AT 808-725-6955.

"RED FLAGS" FOR WORKERS' COMPENSATION FRAUD

Workers' compensation fraud is a problem that costs everyone – you, your employees, and ProService Hawaii. Fraudulent workers' compensation claims create higher costs, compromise standards of care, and add additional delay in returning employees to health and well-being.

The following are some red flags that may signal a fraudulent claim. Please note that these signals, by no means, indicate that a claim is fraudulent. However, you should contact ProService immediately if you suspect workers' compensation fraud.

POSSIBLE SIGNS OF WORKERS' COMPENSATION FRAUD:

- *Claimant reports an alleged injury immediately following disciplinary action, notice of probation, demotion or being passed over for promotion.*
- *Claimant took unexplained or excessive time off prior to claimed injury.*
- *The alleged injury occurs prior to or just after a strike, layoff, plant closure, job termination, completion of seasonal or temporary work, notice of employer relocation, etc.*
- *The social security number provided does not belong to the claimant.*
- *Claimant refuses to or cannot produce solid or correct identification.*
- *Accident occurs in an area where employee would normally not be working.*
- *Action preceding the accident has nothing to do with employee's job duties.*
- *Members of a claimant's family know nothing about the claim.*
- *Concerns are raised by law enforcement officials regarding the claimant's accident or past accidents.*
- *Claimant is having financial difficulties.*
- *Claimant is never home or his/her spouse or family member answers phone call and indicates the claimant will "be back in a few minutes" etc.*
- *There are discrepancies in the claimant's story.*
- *Claimant is an employee who moves from job to job.*
- *Claimant is eager to settle and inquires about settlement early in the life of the claim.*
- *There are no witnesses to the incident (other employees were not aware of claimants injury).*
- *Details of the accident are vague.*
- *The accident is reported on Monday. (The incident may have occurred during time off.)*
- *The claimant is a new hire.*
- *Facts regarding the accident are recorded differently in various medical reports, statements and employer's first report of injury.*
- *Claimant cannot be reached at home during working hours, while receiving disability benefits.*
- *Several of claimant's family members are receiving workers' compensation, unemployment, social security, welfare, etc.*
- *Claimant immediately retains legal counsel.*

QUESTIONS? CONTACT PROSERVICE HAWAII CLAIMS DEPARTMENT AT 808-725-6955.