PROGRESSIVE EMPLOYER MANAGEMENT COMPANY
Payroll • Workers' Comp • Benefits • HR

WORKERS' COMPENSATION CLAIMS REPORTING PROCEDURES

Report all workers' compensation injuries immediately by calling **1.888.925.2990 and pressing 5**. You will be connected with Progressive Employer Management Company's (PEMCO) workers' compensation carrier who will collect the information about your injured employee and initiate the claims process. Representatives are available **24 hours a day, 7 days a week**, to assist you.

Any workers' compensation injury should be reported by the business owner or designee as soon as possible, and in all cases **within 24 hours** of the occurrence of the accident.

If the injury is life threatening, call 911 or seek treatment at the nearest hospital.

Claims Reporting Steps:

- Complete the Accident / Injury Report Form (included in this packet). You will need this information when you report the claim.
- Call **1.888.925.2990 and press 5** to report the claim to our Carrier representative. **Notify the representative that you are a client of Progressive Employer Management Company** and provide them with our **policy number: WC0110484.**
    - You will be given a claim number at the end of your call. Be sure to make note of this claim number on the Accident / Injury Report form and include it on the Treatment Authorization to ensure the claim is handled in a timely manner.
    - The Claims representative will provide you with a list of authorized facilities in your area where you can send your injured employee for treatment.
- Complete the following forms and send them with the injured employee to the treatment facility.
    - Treatment Authorization
    - Pharmacy First Fill Authorization
- Remind your injured employee that a post-accident drug test will be performed at the treatment facility.

TREATMENT AUTHORIZATION

The Treatment Authorization is included in this claim packet. Please make additional copies as needed. This form must be completed and taken to the treatment facility by the injured employee in order to ensure the timely payment of claims related medical bills. Please provide all requested information on the form **including the claim number** that you receive when reporting the claim.

PHARMACY FIRST FILL PROGRAM

The First Fill Program is a single-use pharmacy authorization that provides an immediate solution for an injured worker's initial prescription needs. When an injury is reported, **complete the Optum temporary pharmacy authorization card and give it to the employee to take with them when they go for treatment.** This program ensures the injured worker receives their initial medications as soon as possible with no out-of-pocket expense and is accepted at most major pharmacies.

To complete the Optum Prescription Drug Card, simply fill in the following information:

- **Member ID** which is a combination of the last four digits of the injured employee's social security number plus the date of injury (DOI).
- **Member Name** which is the injured employee's first and last name.

ACCESSING A PROVIDER FOR TREATMENT

The Carrier representative will provide information about the nearest authorized treatment facilities for your injured employee. If you have additional questions or would like to have a directory provided to you, please contact the PEMCO Claims Team at claims@progressiveemployer.com or 1.888.925.2990 x 20808.
If you are located in Georgia, refer to your Physician Panel list for treatment facilities within your area. If you have worksites in Georgia and do not have a Physician Panel, contact us at claims@progressiveemployer.com and we will assist you in obtaining one.

QUESTIONS / SUPPORT

If you have any questions about claims reporting, please contact your Client Relations Manager or the Claims Team at Progressive Employer Management Company (PEMCO).

Claims Team email: claims@progressiveemployer.com
Claims Team phone: 1.888.925.2990 x20808

Electronic copies of this Claims Reporting Procedure, as well as the referenced forms, can be found on PEMCO PULSE (www.pemcopulse.com) under the Forms section for download and printing as needed.

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ACCIDENT/INJURY REPORT

Claim Number (required):	**Policy Number:** WC0110484

Complete all sections of this form prior to reporting a work-related injury as this information is required when reporting a claim. Report all workers' compensation injuries **immediately** by calling **1.888.925.2990 and pressing 5**.

Once you have reported the injury, send this completed form to our Carrier via Fax: 407-660-0339 or email: usz.zurich.claims.documents@zurichna.com.

NOTE: Claims must be reported by calling 1.888.925.2990. *Submitting this report via fax or email does not constitute reporting a claim and will delay treatment of your injured employee as well as adjuster assignment and claims processing.*

CLIENT INFORMATION

Client Name: _____ Client Number: _____

Address: _____ Phone Number: _____

City, State, Zip: _____ Client Contact: _____

INJURED EMPLOYEE INFORMATION

Employee should complete this section.

Employee Name: _____ Phone Number: _____

Address: _____ City, State, Zip: _____

Social Security Number: _____ Job Title: _____

Date of Hire: _____ Date of Birth: _____ Rate of Pay: $_____per _____

ACCIDENT INFORMATION

Date of accident: _____ Time of accident: _____ ◯ AM ◯ PM

Date and time accident was first reported to management:_____ ◯ AM ◯ PM

Address where accident occurred: _____

Has employee returned to work? ◯ Yes ◯ No If yes, indicate the date the employee returned to work: _____

Provide a detailed description of the accident ***including the extent of injuries and body part affected****. Supervisor can complete this section if employee is unavailable.*

Were there any witnesses? ◯ Yes ◯ No If yes, please furnish names, addresses and phone numbers: _____

Please Note: Post-Accident Drug Screening is Required

Employee Signature: _____ **Employer Signature**: _____

I, _____ , was offered medical treatment and am refusing at this time. Date: _____

Employee Signature: _____ **Employer Signature**: _____

PROGRESSIVE EMPLOYER MANAGEMENT COMPANY
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ZURICH

TREATMENT AUTHORIZATION

Employee Name:	**Claim Number (required):**	
Social Security Number:	**Date of Accident:**	
Nature of Injury and Body Part:		
PEMCO Client Name:		
Treatment requested by:	**Title:**	**Date:**

Please accept this as our request for you to provide initial treatment to the above injured employee. It is important to us that our employee receives quality medical care in a timely manner as is necessary to treat their injury and we appreciate your assistance in this process.

We require the completion of a post-accident 5-Panel drug test and authorize you to utilize your chain of custody form.

Please submit all medical records, bills and documentation directly to our workers' compensation carrier, Zurich, and be sure to reference the Zurich **Claim Number** noted above on any documentation sent to Zurich.

Documentation can be submitted through one of the following methods:

Email: usz.zurich.claims.documents@zurichna.com

Zurich's Online Portal: https://claimsdocupload.zurichna.com/ClaimDocumentUpload.aspx

Mail: Zurich North America Claims
PO Box 968084
Schaumburg, IL 60196

Fax: 407-660-0339

Dear Injured Worker,

Optum® has been selected by your company to assist you in acquiring your prescription drugs. This form will provide you with the **convenience** of getting your workers' compensation medications at almost any pharmacy. There will be absolutely **no out-of-pocket expense**. Simply fill in your name and ID (last 4 digits of Social Security Number + DOI; no spaces) and present this form at the pharmacy when getting your prescriptions filled.

This form has been authorized for any of your **workers' compensation** prescriptions from your **authorized workers' compensation** physician. There are over 70,000 (nine out of ten) pharmacies in our national network. You may use your local pharmacy, call our toll free number for a list of other convenient pharmacies in your area, or go to www.cypresscare.com and use the pharmacy locator.

If you have any questions about the usage of this form or would like to discuss having your work-injury medications conveniently sent directly to your home, please call our toll-free customer service number: **1-800-419-7102**

Should you encounter any delays at the pharmacy for any reason, please have the pharmacy contact us immediately for assistance at **1-800-419-7102**.

To the Employer: Please be sure cards are filled out properly with Member ID and Name.

Sincerely,
Patient Care

Workers' Compensation Prescription Drug Card

Group Number:	CCZNACLIENT	**BIN #:**	**010876**
Member Id:		(Last four digits of SSN + DOI) (Example: 9999050106)	
Member Name:		(Patient First & Last Name)	

Pharmacy Help Desk 1-800-419-7102

To verify eligibility or to locate a participating pharmacy call 1-800-419-7102.
To locate a pharmacy you can also visit www.cypresscare.com