

Accident Investigation Kit

Accident Investigation Forms

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 AccidentFund

 UnitedHeartland

 CompWest

 ThirdCoast Underwriters

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Post-Accident Checklist

If a serious trauma or medical condition occurred, seek immediate medical treatment or call 911.

For non-emergency accidents, ensure the injured employee(s) is directed to the designated occupational clinic and follow any drug or alcohol testing mandated by your company policy. Inform the physician that the company will attempt to accommodate modified duty work, if needed, and ask the physician to address the injured employee's work capabilities and/or recommended work restrictions.

1. Preserve the scene and gather details.

Preserve any/all failed equipment and evidence that may have contributed to the incident until the claim is fully investigated. Take photos of the scene or condition. Interview the injured person(s) to fully understand the extent of injury/injuries. Ask them to explain/demonstrate how, when, where and why the injury occurred.

2. Present the injured employee(s) with the following:

All written statements should be completed by the injured employee(s) in their own words, signed and dated.

- **Employee Report of Injury Form:** Ensure the information on the form is consistent with information shared during the interview. Discuss any discrepancies to understand where disconnect may have occurred during the interview. Request employee amend and clarify their statement as necessary to align with their verbal explanation.
- **Medical Communications Authorization:** At the time of reporting the incident, the injured person(s) should review and sign the medical communications authorization form. This document will allow us to obtain all necessary medical information to advance the claims handling process as quickly as possible.
- **Declination of Treatment:** In the event that an employee declines medical treatment following a workplace incident, inform them that an incident will be filed with the insurance carrier and the carrier may call them. In addition, explain that the company will follow up with them over the following days to confirm their condition is improving and eventually has resolved. If care is necessary, the company will assist them in seeking care. If care is not needed, the employee will be expected to sign the bottom portion of the Declination of Treatment affirming the injury has resolved without receiving treatment and everyone can close their file knowing the employee is well. **This process should be fully explained at the time the employee first declines treatment.**

3. Perform investigation summary.

All written statements should be completed by the supervisor in their own words, signed and dated.

- **Supervisor Accident Investigation Summary:** This report should include all relevant details about the incident and process/tool/systems failures. The supervisor's statement should reflect their own conclusions they considered all statements and physical evidence. *The supervisor's statement should reflect their own conclusions and should be completed by the supervisor in their own words, signed and dated.*

4. Identify witnesses and gather statements.

All written statements should be completed by each individual witness in their own words, signed and dated.

- **Witness Incident Report:** This report should include relevant details from the perspective of all witnesses. Follow the same statement gathering process for all witnesses.

5. Report the incident to your workers' compensation carrier.

Reporting the incident to your workers' compensation carrier (Accident Fund, United Heartland, Third Coast Underwriters or CompWest) within 24 hours of the incident helps ensure Claims teams can begin processing the incident as quickly as possible.

6. Other important details to share with the injured employee(s):

Find these and other resources on our website.

- Prescription first fill form, if pharmaceuticals are needed.
- Information on claim texting capabilities (including real-time language translation).
- Preferred vendor utilization letter template for physicians to streamline continuity of care for injured person(s).
- Digital Customer Portal (DCP) account access for billing, electronic funds transfer (EFT) sign up, receipt collection, claim handler notes, etc.



Employee Report of Injury

Form to be completed by the injured worker.

CONTACT

Name (first, middle, last): _____
 Street address: _____ Suite/Apt./Other: _____ City: _____ State: _____ Zip code: _____
 Date of birth: _____ Social Security number: _____
 Home phone: (____) _____ Cell phone: (____) _____ Work phone: (____) _____
 Email: _____ Emergency contact name: _____ Phone: (____) _____
 Primary language: English ☐ Spanish ☐ Polish ☐ Other: _____

PERSONAL

Height: _____ Weight: _____ Gender: Male ☐ Female ☐ Prefer not to disclose ☐
 Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other: _____ Number of dependents: _____ List dependent date(s) of birth or leave blank if not applicable: _____
 Are you financially responsible for anyone else? (Y/N) _____ If yes, state whom you are responsible for and why: _____

EDUCATION

Highest level of education completed: GED ☐ High school ☐ Two-year degree ☐ Four-year degree ☐ Graduate degree or higher ☐
 Where did you complete your highest level of education? _____
 List specializations/certifications: _____

EMPLOYMENT

Company name: _____ Supervisor: _____ Date of hire: _____
 Job title: _____ Weekly wage: _____ Hourly rate: _____ Hours per week: _____ Salary (if applicable): _____
 Do you work overtime (O/T)? (Y/N): _____ If yes, how many O/T hours do you work weekly? _____ Is O/T mandatory? (Y/N) _____
 Are you a member of a union? (Y/N): _____ If yes, name of union: _____ Year you became a union member: _____
 Were you injured as a result of your employment with the above employer? (Yes/No) _____ If yes, list lost wages due to your injury: _____

SECONDARY EMPLOYMENT

If you had a second job at the time of your injury, provide employer name, address, phone: _____
 If self-employed or own your own business, provide company name and nature of business: _____

INCIDENT INFORMATION

Date and time of incident: _____ Exact address/location where occurred: _____
 Date reported to supervisor: _____ Name of supervisor(s) incident was reported to: _____
 Supervisor(s) on duty at the time: _____
 Describe step-by-step what led up to the incident and what you were doing when you were injured: _____

Were you performing work duties as instructed? (Y/N): _____ If yes, who provided this instruction? _____
 If you were not instructed to perform this duty, explain why you were doing it: _____
 What would have prevented the injury? _____

List any unsafe conditions that contributed to your injury, if any: _____
 If you were going to perform the same task again, state what you would do differently and why: _____

TOOL/DEVICE FAILURE *(If not applicable, leave blank.)*

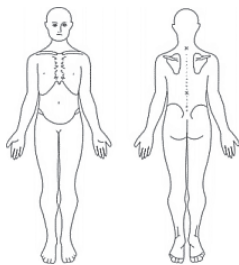
Did a tool/device failure contribute to or cause your injury? (Y/N) _____ If yes, explain: _____

 Identify the make, model and manufacturer serial number: _____
 Were you instructed to use the tool/device? (Y/N) _____ If yes, who instructed you to use the tool/device? _____
 Were you following instructions for proper usage? (Y/N) _____ Where is the tool/device located now? _____



INJURY DETAILS

Draw an arrow pointing to any direct traumas. Place an "X" where you have pain, and describe the type of pain next to the affected area(s).



List all part(s) of your body that were injured: _____

Describe the type/nature of injury to each body part injured: _____

MEDICAL CARE

Were you hospitalized (Y/N)? _____ Which hospital? _____ How long? _____

List all physicians and facilities that have treated you for this injury (name, address, phone): _____

Who is your current, primary treating physician? (name, address, phone): _____

When was your first doctor's appointment for this injury (not including hospitalization)? _____

When is your next doctor's appointment for this injury? _____ Is ongoing treatment or physical therapy required? (Y/N) _____

WORK RESTRICTIONS

Has a physician restricted you from working in any capacity as a result of this injury? (Y/N) _____ If yes, for how long? From _____ to _____

Has a physician authorized to take off work completely? (Y/N) _____ If yes, for how long? From _____ to _____

Do you have a possible return to work date? (Y/N) _____ When? _____ Did you present a doctor's note to your employer? (Y/N) _____

If yes, on what date did you present it and to whom? _____

MEDICAL HISTORY AND PRIOR WORK RESTRICTIONS

List any underlying health problems you have that may complicate your recovery (such as diabetes, hypertension, etc.): _____

Have you ever had an MRI or CT-Scan? (Y/N) _____ If yes, on what body part(s), where were they performed, when were they performed, and what were the findings? _____

Did you previously injure any of these body parts? (Y/N) _____ If yes, state what body part was injured, what the previous diagnosis was, and when you were discharged from care for each condition: _____

State with whom you treated for each condition: _____

Did any physician ever place a permanent restriction on you? (Y/N) _____ If yes, list the restriction placed on you, state who placed the restriction, and when: _____

Have you ever filed for workers' compensation benefits before? (Y/N) _____ If yes, list the state where you filed for benefits, the employer you worked for at the time, and what the injury was that you sustained? _____

WITNESSES

List all witnesses to the injury: _____

Outside earnings earned while receiving workers' compensation benefits must be immediately reported to the workers' compensation carrier. Promptly report any restrictions placed on you to your employer so they may attempt to accommodate your restrictions. Advise your physician that they must address what work you are capable of performing, or what restriction is required, if any, at every appointment. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

I certify I have read the information on this sheet and have answered the questions fully, truthfully and to the best of my knowledge.

Name (printed): _____ Signature: _____ Date: _____



Supervisor Accident Investigation Summary

CONTACT

Name: _____ Job title: _____
 Street address: _____ Suite/Apt./Other: _____ City: _____ State: _____ Zip code _____
 Phone: (____) _____ Project name/location (if applicable): _____
 How long have you been on this job site? _____ How long has the injured employee been employed? _____

INJURED EMPLOYEE INFORMATION

Name of injured employee: _____ Injured employee phone number: _____
 Occupation of injured employee: _____
 Nature of injury sustained (cut, broken bone, etc.): _____
 Part(s) of body injured (be specific): _____

Did employee miss days of work (Y/N)? _____ If yes, how many work days were missed? _____ Did the employee return to normal work schedule (Y/N)? _____ If yes, date of return: _____ Are/were modified job duties required (Y/N)? _____ If yes, explain: _____

INCIDENT INFORMATION

Date and time of incident: _____ Exact address and details where injury occurred: _____

What task was being performed at the time of the incident? _____

What went wrong? _____

Were proper task instructions provided (Y/N)? _____ Was the employee following these instruction at the time of the incident (Y/N)? _____
 Explain: _____

Did the employee utilize all safety equipment and follow all safety procedures at the time of loss (Y/N)? _____ Explain: _____

Who/what contributed to the accident? Explain: _____

Is there anything you will do differently as a supervisor as a result of this accident? _____

TOOL/DEVICE FAILURE *(Reminder: Always preserve evidence and take photos. Skip section if not applicable.)*

If tool/device failure occurred, identify the make, model and manufacturer serial number: _____

Where is the tool/device located now? _____

Was the employee instructed to use the tool/device?(Y/N) _____ If yes, were proper tool/device usage instructions provided? (Y/N) _____ If yes, who provided instruction? _____

WITNESSES *(Reminder: All witnesses should independently complete the Witness Incident Report form.)*

List names, addresses and phone numbers of all witnesses: _____

I certify I have answered the questions fully, truthfully and to the best of my knowledge.

Name (printed): _____ Signature: _____ Date: _____



Witness Incident Report

Each individual witness should complete and sign this report. Do not include information you did not see or hear yourself.

Witness name/job title: _____ Witness phone: _____

Witness address: _____

Name of injured person(s): _____

Date and time of incident: _____ Relationship to the injured employee: _____

Did you see the incident happen? (Y/N) _____ Describe the nature of the injuries sustained by the injured employee: _____

Describe in detail what you witnessed, how the accident occurred and include relevant events that led up to the incident: _____

Could this incident have been prevented? (Y/N) _____ If no, how could it have been prevented? _____

Did the employee utilize all safety equipment and follow all safety procedures at the time of loss? (Y/N) _____ Explain: _____

Who/what contributed to the accident? Explain: _____

Note any other important details here: _____

I certify I have answered the questions fully, truthfully and to the best of my knowledge.

Name (printed): _____ Signature: _____ Date: _____



Witness Incident Report

Each individual witness should complete and sign this report. Do not include information you did not see or hear yourself.

Witness name/job title: _____ Witness phone: _____

Witness address: _____

Name of injured person(s): _____

Date and time of incident: _____ Relationship to the injured employee: _____

Did you see the incident happen? (Y/N) _____ Describe the nature of the injuries sustained by the injured employee: _____

Describe in detail what you witnessed, how the accident occurred and include relevant events that led up to the incident: _____

Could this incident have been prevented? (Y/N) _____ If no, how could it have been prevented? _____

Did the employee utilize all safety equipment and follow all safety procedures at the time of loss? (Y/N) _____ Explain: _____

Who/what contributed to the accident? Explain: _____

Note any other important details here: _____

I certify I have answered the questions fully, truthfully and to the best of my knowledge.

Name (printed): _____ Signature: _____ Date: _____



Medical Communications Authorization

I unconditionally authorize all medical doctors, licensed physicians, medical practitioners, surgeons, doctors of osteopathy, chiropractors, any medical related facilities, insurance companies, other organizations, corporations, institutions, or persons that have any records, knowledge or information, including my mental or physical health, history, condition or welfare, to supply all such information to my employer and its insurers, including Accident Fund Insurance Company of America, Accident Fund General Insurance Company, Accident Fund National Insurance Company, United Wisconsin Insurance Company, CompWest Insurance and Third Coast Underwriters, their third party claims administrators, attorneys, consultants, nurses and vendors which may participate in the evaluation and recruitment of information to determine my entitlement to benefits under any workers compensation or occupational disease acts, or in the coordination of medical or vocational rehabilitation. This authorization includes, but is not limited to, the furnishing and delivery of reproduced or photographic copies of notes, reports, records, intake form and films.

I expressly authorize any treating physician or other medical care provider to communicate orally or in writing with the above described entities regarding my past, present and future care and treatment, and to any other issues including but not limited to my diagnosis, prognosis, the causal connection of any injury or condition of ill being to my employment, treatment plan, nature and extent of injury, and my ability to work. I hereby waive any doctor-patient privilege resulting from any consultation, examination, or treatment with or by you, and any relevant regulations under the Health Insurance Portability & Accountability Act. In addition, any treating physician or medical provider is authorized to review and discuss any additional records, films or information provided to them.

I understand that the persons, organizations or above referenced entities that I am authorizing to share and communicate my information to may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits based on my decision to sign this authorization. I know that federal law may not protect my information once it is disclosed, and that my information may be shared with someone else after it is disclosed. I understand I have the right to rescind this authorization at any time, and that revocation of this authorization must be made in writing.

I know that any communications or actions made prior to the revocation of this authorization will not be impacted by a revocation.

A photocopy of this authorization shall be as valid as the original. This release will remain valid for the duration of my worker's compensation or occupational disease claim, unless expressly rescinded in writing. I understand that after signing this authorization, I will be provided with a copy of it.

I have read and understand the information contained in this medical and communications release.

Social Security Number: _____ Date of Birth: _____

Signature: _____ Date: _____

Print Name: _____

Address: _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.



Declination of Treatment

It is our policy to provide prompt and appropriate medical treatment to employees for work related injuries. There are situations that arise where notice of an injury may be made, and formal treatment may not be necessary.

When an employee reports a work related injury, the injury will be documented and treatment will be offered. An employee may indicate a preference not to have formal medical treatment. In the event that an employee declines medical treatment, we will have the employee sign this document indicating that they declined medical treatment. The company will continue to monitor the resolution of the complaints or injury until the time that the condition has been completely resolved. The employee will be asked to sign off that the condition has completely resolved.

In the event that a condition is not improving readily during the monitoring period, or should the condition worsen, the employee will be sent for an evaluation to make sure the condition is properly addressed. There may be situations where an employee is sent for a medical clearance examination following their report of injury, even though the injured employee has declined medical treatment.

Date of Injury: _____

Injured Employee's Name _____

Supervisor's Name: _____

Body Part(s) Injured: _____

I am declining medical treatment at this time. Should my condition worsen or should I change my mind regarding treatment, I acknowledge I must inform my supervisor immediately. Date: _____

Injured Employee's Signature: _____

Supervisor's Signature: _____

My injury/injuries have completely resolved. Date: _____

Injured Employee's Signature: _____

Supervisor's Signature: _____



Sample Vendor Utilization Letter to Physician

Providing key information to treating providers up-front can help improve preferred vendor utilization and streamline and improve the continuity of care for injured workers. **To request a letter with the most current billing and provider referral information, contact your dedicated claim representative.**

April 17, 2023

Provider Name
123 South Main Street
City, State, 48823

Email/Fax: xxx-xxx-xxxx

RE:
DOB:
Injury/Body Part:
Date of Injury:
Employer:
Claim Number:

Dear Treating Provider,

We have an open and billable claim for the injured worker referenced on the enclosed form. **forward a copy of your medical chart and bills for the treatment of the injured worker for consideration – and accept this as an ongoing request for a faxed work authorization following each visit.**

Note: The employer will do everything possible to return their injured worker to work.

Should medical services be required, please expedite the process by initiating a referral to the providers listed on the enclosed form. Once the referral is made, the ancillary services are undersigned for prompt authorization, where allowed by law. Use of these services is subject to the terms and conditions of the applicable policy.

Feel free to contact the undersigned with any questions.

Sincerely,

[Full contact information and fax number]

Enclosure: Billing and Ancillary Provider Referral Information

Billing and Ancillary Provider Referral Information

RE:
DOB:
Injury/Body Part:
Date of Injury:
Employer:
Claim Number:

Medical Services

Phy	Service	Phone	Fax	Email
	One Call Medical	877-225-67	904-394-8266	onecallm.com
	MedRisk	800-225-967		medriskreferrals@medrisknet.com
	Orchid Medical	866-888-6724	866-246-8587	referrals@orchidmedical.com
	MTI America	877-512-5742	954-343-1779	AFGroup@MTIamerica.com
	Call Care Management	877-225-6785	904-394-8369	AFGroup@onecallm.com
	Orchid Medical	866-888-6724	866-246-8587	referrals@orchidmedical.com
	VGA Homelink	877-711-3171	844-851-6419	AFGroupHomelink@vgm.com
	MTI America	877-512-5742	954-343-1779	afgroup@MTIamerica.com
	Northwood	877-684-9275	866-895-7207 x2550	referral@northwoodinc.com
	Optum	844-880-0565	800-419-7194	owcaorders@optum.com

Pharmacy

Pharmacy	My Matrix
PCN	WC
Bin Number	003858
Processor	A4
United Heartland Group Number	KQSA

Compound creams require a letter of medical necessity and pre-authorization, except where precluded by law.

Billing

AF Group Billing Address	AF Group – Third Coast Underwriters PO Box 40790, Lansing, MI 48901
Questions regarding bill status should be directed to Provider Relations at 866-206-5851.	
Medical Bill Electronic Clearinghouse	WorkComp EDI 4250 Veterans Memorial Hwy, Ste. 301E Holbrook, NY 11741
WorkComp EDI Customer Service Contact	Marisa Nappi Phone: 800-297-6909 x1303 // Fax: 631-648-5023 // Email: info@workcompedi.com
WorkComp EDI Payer Numbers	United Heartland WB471

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