NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Name of employer] _____ has workers' compensation insurance coverage from [name of commercial insurance company] Normandy Insurance Company in the event of work-related injury or occupational disease. This coverage is effective from [effective date of workers' compensation insurance policy] _____. Any injuries or occupational diseases which occur on or after that date will be handled by [name of commercial insurance company] Normandy Insurance Company _____. An employee or a person acting on the employee's behalf, must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

COVERED EMPLOYER

Texas Workers' Compensation Rule 110.101(e)(1) requires employers who are covered by workers' compensation through a commercial insurance company to advise their employees that they do have workers' compensation insurance coverage and to advise their employees of the Texas Department of Insurance, Division of Workers' Compensation's toll free number to obtain additional information about their workers' compensation rights.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

1. Prominently displayed in the employer's personnel office, if any;
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type; and
4. Contain the exact words as prescribed in Rule 110.101(e)(1).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

Do Not Post This Side

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [Name of the employer] _____ _____tiene cobertura de seguros de compensación para trabajadores con [name of the commercial insurance company] Normandy Insurance Company para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde [effective date of workers' compensation insurance policy] _____. Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por [name of commercial insurance company] Normandy Insurance Company _____. Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO: La División proporciona información gratuita sobre cómo presentar una reclamación de compensación para trabajadores. El personal de la División contestará cualquier pregunta que usted pueda tener sobre la compensación para trabajadores y procesará cualquier solicitud de resolución de disputas relacionada con una reclamación. Usted puede obtener este tipo de asistencia comunicándose con su oficina local de la División o llamando al teléfono 1-800-252-7031. La Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés) también ofrece asistencia gratuita a los empleados lesionados y ellos le explicarán cuáles son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores. Usted puede obtener la asistencia de OIEC comunicándose con un representante de servicio al cliente de OIEC en su oficina local de la División o llamando al 1-866-EZE-OIEC (1-866-393-6432).

LÍNEA DIRECTA PARA REPORTAR VIOLACIONES DE SEGURIDAD: La División cuenta con una línea gratuita telefónica que está en servicio las 24 horas del día para reportar condiciones inseguras en el área de trabajo que podrían violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen en contra de cualquier empleado porque él o ella de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la División al teléfono 1-800-452-9595.

EMPLEADOR CON COBERTURA

El Reglamento 110.101 (e)(1) de Compensación para Trabajadores de Texas requiere que los empleadores que cuentan con una cobertura de compensación para trabajadores mediante una compañía de seguros comercial notifiquen a sus empleados que ellos cuentan con una cobertura de seguro de compensación para trabajadores e informen a sus empleados sobre el número de la línea telefónica gratuita del Departamento de Seguros de Texas, División de Compensación para Trabajadores para obtener información adicional sobre sus derechos de compensación para trabajadores.

Avisos en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista y:

1. Mostrarse en un lugar prominente de la oficina de personal del empleador, si es que la hay;
2. Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;
3. El título debe ser impreso en tamaño 26, en letra negrita de punto, el tema debe ser impreso en tamaño 18, en letra negrita de punto, y el texto, por lo menos en tamaño 16 en letra negrita de punto normal; y
4. Contener las palabras exactas según lo señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra al reverso de esta página cumple con los requisitos que se han señalado en la parte de arriba. El negarse a mostrar o proporcionar esta información, según lo requerido en el reglamento es una falta a la ley y a los reglamentos de la División. El infractor podría estar sujeto a sanciones administrativas.

NO MOSTRAR ESTE LADO

THÔNG BÁO CHO CÁC NHÂN VIÊN VỀ VIỆC BỒI THƯỜNG LAO ĐỘNG Ở TEXAS

PHẠM VI BẢO HIỂM: [Tên chủ nhân] _____ _____ có phạm vi bảo hiểm bồi thường lao động của [tên công ty bảo hiểm thương mại] Normandy Insurance Company _____trong trường hợp có những thương tích liên quan đến công việc hoặc những bệnh tật do nghề nghiệp tạo ra. Phạm vi bảo hiểm này có hiệu lực từ [ngày hiệu lực của hợp đồng bảo hiểm lao động] _____. Bất cứ thương tích hoặc bệnh tật do nghề nghiệp tạo ra xẩy ra vào ngày hoặc sau ngày đó sẽ được giải quyết bởi [tên của công ty bảo hiểm thương mại] Normandy Insurance Company _____. Một nhân viên hoặc một người có quyền thay mặt người nhân viên đó phải thông báo cho chủ nhân về thương tích hoặc bệnh tật do nghề nghiệp tạo ra không quá ngày thứ 30 sau ngày thương tích xảy ra hoặc ngày mà nhân viên biết hoặc lẽ ra phải biết về bệnh tật do nghề nghiệp tạo ra, trừ phi Cơ Quan Bảo Hiểm Tiểu Bang Texas, Ban Bồi Thường Lao Động (Ban) xác nhận rằng việc không thông báo kịp thời là có nguyên nhân chính đáng và hợp lý. Chủ nhân của bạn bắt buộc phải cung cấp cho bạn những thông tin liên quan đến việc bảo hiểm, bằng văn bản, khi bạn được thuê tuyển hoặc bất kỳ lúc nào chủ nhân bắt đầu hoặc chấm dứt bảo hiểm bồi thường lao động.

HỖ TRỢ CHO NHÂN VIÊN: Ban Bồi Thường Lao Động cung cấp thông tin miễn phí về cách thức nộp hồ sơ yêu cầu bồi thường lao động. Nhân viên của Ban sẽ trả lời bất cứ câu hỏi nào bạn có thể có liên quan đến việc bồi thường lao động và tiến hành bất cứ yêu cầu nào để giải quyết sự tranh chấp yêu cầu thanh toán. Bạn có thể nhận được sự hỗ trợ này bằng cách liên lạc với văn phòng địa phương của Ban hoặc gọi số 1-800-252-7031. Văn Phòng Cố Vấn Cho Nhân Viên Bị Thương Tích (OIEC) cũng cung cấp sự hỗ trợ miễn phí cho các nhân viên bị thương tích và sẽ giải thích những quyền lợi và trách nhiệm của bạn theo Đạo Luật Bồi Thường Lao Động. Bạn có thể nhận được sự hỗ trợ của OIEC bằng cách liên lạc với người đại diện dịch vụ yểm trợ của văn phòng OIEC địa phương của bạn hay gọi số 1-866-EZE-OIEC (1-866-393-6432).

ĐƯỜNG GIÂY NÓNG VỀ VI PHẠM AN TOÀN: Ban Bồi Thường Lao Động có số điện thoại miễn phí hoạt động 24/24 để nhận báo cáo những dữ kiện mất an toàn nơi làm việc mà có thể vi phạm đến sức khỏe nghề nghiệp và luật an toàn. Luật pháp cấm chủ nhân đình chỉ, sa thải, hoặc phân biệt đối xử với bất kỳ nhân viên nào bởi vì người này đã báo cáo một cách trung thực mọi sự vi phạm về sức khỏe nghề nghiệp hoặc an toàn. Xin liên lạc với Ban Bồi Thường Lao Động ở số 1-800-452-9595.

COVERED EMPLOYER

Texas Workers' Compensation Rule 110.101(e)(1) requires employers who are covered by workers' compensation through a commercial insurance company to advise their employees that they do have workers' compensation insurance coverage and to advise their employees of the Texas Department of Insurance, Division of Workers' Compensation's toll-free number to obtain additional information about their workers' compensation rights.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:1.

1. Prominently displayed in the employer's personnel office, if any;2.
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;3.
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in
4. at least 16 point normal type; and4.
5. Contain the exact words as prescribed in Rule 110.101(e)(1).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

Do Not Post This Side

Employer Rights and Responsibilities

Information for Employers from the Division of Workers' Compensation

Workers' Compensation Insurance Coverage

Workers' compensation insurance coverage provides covered employees with income and medical benefits if they sustain a work-related injury or illness. Except as otherwise provided by law; Texas private employers can choose whether or not to provide workers' compensation insurance coverage for their employees. Except in cases of gross negligence or an intentional act or omission of the employer, workers' compensation insurance limits an employer's liability if an employee brings suit against the employer for damages. Certain building or construction employers who contract with governmental entities are required to provide workers' compensation coverage for each employee working on the public project. Some clients may also require their contractors to have workers' compensation insurance.

Providing Workers' Compensation Insurance

If employers choose to provide workers' compensation, they must do so in one of the following ways:

- purchase a workers' compensation insurance policy from an insurance company licensed by the Texas Department of Insurance (TDI) to sell the coverage in Texas;
- be certified by the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) to self-insure workers' compensation claims; or
- join a self-insurance group that has received a certificate of approval from the TDI.

Note: Political subdivisions may self-insure, buy coverage from insurance companies, or enter into inter-local agreements with other political subdivisions that self-insure.

EMPLOYER RIGHTS

Covered employers have the following rights:

- the right to contest the compensability of a workers' compensation claim if the insurance carrier accepts liability for payment of benefits;
- the right to be notified of a proposal to settle a claim or of any administrative or judicial proceeding related to resolution of a claim (after making a written request to the insurance carrier);
- the right to attend dispute resolution proceedings related to an employee's claim and present relevant evidence about the disputed issues;
- the right to report suspected fraud to the TDI-DWC or to the insurance carrier;
- the right to contest the failure of the insurance carrier to provide required accident prevention services; and
- the right to receive return-to-work coordination services as necessary to facilitate an employee's return to employment.

To dispute a workers' compensation claim, an employer may file the DWC Form-004, and the DWC Form-045, *Request to Schedule, Reschedule or Cancel a Benefit Review Conference (BRC),* which may be obtained from the TDI website at http://www.tdi.texas.gov/forms/form20employer.html or by calling 1-800-252-7031.

Non-Reimbursable Employer Payments

An employer is not entitled to and cannot seek reimbursement from the employee or insurance carrier if after a work-related injury or illness they voluntarily:

- continue to pay the injured employee's salary continuation; or
- pay the injured employee salary supplementation to supplement income benfits paid by the insurance carrier.

Employer Voluntary Payments of Benefits

An employer may voluntarily pay income or medical benefits to an employee during a period in which the insurance carrier has:

- contested compensability of the injury;
- contested liability for the injury; or
- has not completed its initial investigation of the injury. *Note:* an employer is only allowed to pay benefits in this situation for the first two weeks after the injury.

For reimbursement, the employer is required to timely report the injury to the insurance carrier and to let the insurance carrier know, within 7 days of beginning

For further assistance, call 1-800-252-7031 or visit

http://www.tdi.texas.gov/wc/employer/index.html

voluntary payments, that voluntary payments are being made. The insurance carrier is only required to reimburse the employer for the amount of benefits the insurance carrier would have paid. If the employer made payments in excess of what the insurance carrier would have paid, the excess amount is not reimbursable, unless there is a written agreement between the injured employee and the employer that the excess amount can be recouped from future impairment income benefits paid by the insurance carrier, if any. The employer must file the DWC Form-002, *Employer's Report for Reimbursement of Voluntary Payment*. The DWC Form-002 may be obtained from the TDI website at http://www.tdi.texas.gov/forms/form20employer.html or by calling 1-800-252-7031.

EMPLOYER RESPONSIBILITIES

Reporting Workers' Compensation Insurance Coverage to Employees

Employers must tell their employees that they carry workers' compensation insurance by providing a written notice of coverage to new employees upon hire. The written notice must inform employees of their right to reject workers' compensation coverage and retain their common law right of action. This notice must be in the wording and format prescribed by TDI-DWC's *New Employee Notice*.

Employers must also post a written notice at their place of business telling their employees that they carry workers' compensation insurance. This notice must be in the wording and format prescribed by TDI-DWC's Notice 6, *Notice to Employees Concerning Workers' Compensation in Texas.* The notice must be in English, Spanish, and any other language that is common to the employees and must be posted at conspicuous locations at the employers' place of business.

A written notice must be provided again to each employee and the Notice 6 must be updated when changes in coverage status (obtained, terminated, or canceled) occur. The TDI-DWC's *New Employee Notice* and Notice 6 may be obtained from the TDI website at http://www.tdi.texas.gov/forms/form20employer.html or by calling 1-800-252-7031.

Reporting Injuries and Illnesses

Employers are required to report to its insurance carrier, within 8 days, any:

- work-related injury resulting in the employee's absence from work for more than one day;
- occupational disease of which the employer has knowledge; and
- work-related fatality.

Employers should report these injuries and illnesses using the DWC Form-001, *Employer's First Report of Injury or Illness*. An employer must keep a record of all work-related injuries, illnesses and fatalities for at least 5 years after the date the record was created, or for the period of time required by the Occupational Safety and Health Administration (OSHA), whichever is longer.

The employer must also provide a copy of the completed DWC Form-001 to the injured employee, along with a copy of the *Notice of the Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System.* The DWC Form-001 may be obtained from the TDI website at http://www.tdi.texas.gov/forms/form20employer.html. The employee's notice of rights and responsibilities may be obtained from the TDI website at http://www.oiec.texas.gov/resources/ierightsresp.html. Both forms may also be obtained by calling 1-800-252-7031.

Employer's Wage Statement & Supplemental Report of Injury

An employer must report an injured employee's wages and other fringe benefits (i.e. health premiums, uniform allowance, etc.) to the insurance carrier. The employer is required to send the DWC Form-003, *Employer's Wage Statement,* to the insurance carrier and the injured employee within 30 days of the earliest of: the date the employer is notified that the employee is entitled to income benefits; or the date of employee's death as a result of a compensable injury.

An employer must also report any changes in an injured employee's pay or employment status to the insurance carrier. The employer must send the DWC Form-006, *Supplemental Report of Injury,* to the insurance carrier and the injured employee within:

- 10 days from the end of a pay period in which an employee's pay changes;
- 10 days from the date an employee resigns or is terminated;
- 3 days from the date the employee begins to lose time from work as a result of the injury;
- 3 days from the date an employee returns to work; and
- 3 days from the date an injury causes an employee to miss additional work after returning to work.

Safe Workplace

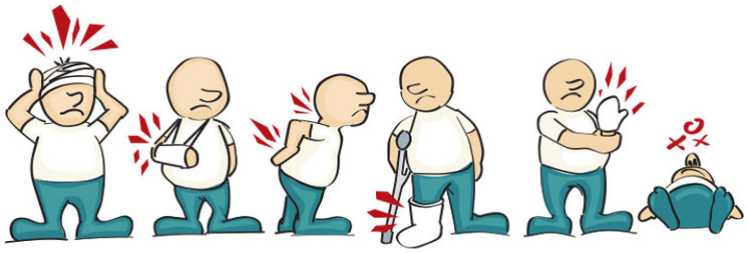
Employers must take all actions reasonably necessary to ensure a safe workplace and take all steps reasonably necessary to protect the life, health and safety of the employees.

Compliance

Employers that fail to comply with workers' compensation requirements commit an administrative violation and may be subject to administrative penalties. The information provided in this fact sheet and workers' compensation requirements are pursuant to: Texas Labor Code §§406.002, 406.005, 406.007, 406.033, 406.034, 406.096, 408.003, 408.001, 409.011, 409.005, 409.006, 411.032, 411.103 and 413.021; and 28 Texas Administrative Code §§110.101, 120.1, 120.2, 120.3, 120.4, 126.13, 129.7 and 160.3.

If you have any questions regarding reporting requirements or compliance with the law, contact TDI-DWC at 1-800-252-7031. For more information on workers' compensation for employers, visit the TDI website at http://www.tdi.texas.gov/wc/employer/index.html.

No matter how large or how small, You must remember to report them all.



Report ALL work-related incidents IMMEDIATELY to your supervisor.

Report every injury that occurs, even if you don't need medical attention.

Any unsafe work conditions should also be reported to your supervisor so that they may be corrected.

How to report a work-related injury

Online · www.normandyins.com

App · www.normandyins.com/claim-app

Download on the App Store · GET IT ON Google Play · Search: Normandy - Claims Reporting

Email · compcare@normandyins.com

Call · 833-968-7642 (833-YOURNIC)

Fax · 833-770-1220

You do not need to wait until the incident report form is completed. Simply report the injury to Normandy Insurance right away with whatever information you have.

Questions?
Call 866-688-6442
Visit us at www.normandyins.com

NORMANDY INSURANCE COMPANY

NORMANDY INSURANCE COMPANY

REPORTING A CLAIM – TEXAS

- Once an employee reports an injury or illness, provide the employee instructions on how to obtain medical care
  - **In an emergency, dial 911** or get the employee to the closest hospital, emergency room or medical facility In a non-emergency situation, the employee should be directed to an urgent care or walk-in clinic you have selected from this list of providers located at this link: https://search.primehealthservices.com/Search

  - Contact the medical provider/facility to let them know that an employee is being sent over for treatment and that a drug test should be completed on the injured employee

- To report a claim, **notify Normandy Insurance IMMEDIATELY (within 24 hours) via:**
  - Phone at **833-968-7642 (833-YOURNIC)** (this is the preferred method of reporting a claim), or
  - Email the completed Employer's First Report of Injury or Illness [*DWC FORM-001 Rev. 10/05*] form to compcare@normandyins.com, or
  - Online at www.normandyins.com, or
  - Fax the completed Employer's First Report of Injury or Illness [*DWC FORM-001 Rev. 10/05*] form to **833-770-1220**
  - Immediate notification of a claim may help reduce the cost of the claim
  - Section 409.005, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness [*DWC FORM-001 Rev. 10/05*] to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death.
  - Your company could be fined by the state for failure to report a claim to your insurance carrier

- If there is a job-related death or hospitalization of 1 or more employees you must notify OSHA **within 8 hours**, and each work-related inpatient hospitalization, as well as amputations and losses of an eye must be reported to OSHA **within 24 hours**. The reporting regulations affect all employers covered by OSHA, even those who are partially exempt from maintaining injury and illness records
  - The Occupational Safety and Health Administration (OSHA) in your state by telephone to the OSHA toll-free central telephone number, 1-800-321-OSHA (1-800-321-6742). Or by electronic submission using the reporting application located on OSHA's public Web site at www.osha.gov.

- Have the injured employee and supervisor and/or witnesses complete an Accident Investigation Report form
  - **NOTE**: **If you do not agree with the description of the accident or believe that an accident did not occur, you are still required to report the incident to Normandy. It is imperative that a claim be reported, even if it is questionable.**

- Maintain continuous contact with the injured employee to let them know that you are concerned about their well-being and that work is available. If an employee is released by their treating physician to return to work in an alternate duty capacity, you should attempt to make the necessary accommodations to bring the injured employee back into the workplace

- You can expect to hear from your adjuster within 24 hours of reporting a claim and also throughout the duration of the claim, but it is important that you also keep in touch with your adjuster.

- Provide your adjuster with any pertinent information that you may have with regard to your claims

- If an employee needs further medical treatment for the same injury or is having problems with claims payments, instruct them to contact their adjuster at 866-688-6442.

- Please visit www.normandyins.com for more information.

NORMANDY INSURANCE COMPANY

Claim Reporting Instructions

To Report A Claim:

Phone: 833-968-7642 (833-YOURNIC)

Online: www.normandyins.com

Email: compcare@normandyins.com

Fax: 833-770-1220

PHONE REPORTING:

If reporting by ***PHONE***, the operator that answers the phone will ask question in regards to the accident. S/he will also obtain some personal information about the injured worker that is required in order to file a workers' compensation claim.

If necessary that operator will either connect the caller with the adjuster in order to obtain physician information in regards to where to treat. If the call is placed after hours that operator will provide the physician information.

FAX OR EMAIL REPORTING:

If reporting by ***FAX*** or ***EMAIL***, claims should be reported on the **State Form DWC-1, First Report of Injuryor Illness.** The following information is required for claim entry:

- Full name, address, telephone number of injured employee
- Occupation, date of birth, sex of injured employee
- The injured employee's Social Security number
- Date and time of accident
- Employee's description of accident
- Injury/illness that occurred, part of body injured
- Company name, phone, address; and policy number, if known
- Employer's location address is different from above
- Did the employee return to work? If so, note the date.
- Do you (the employer) agree with the accident?
- Name of physician or hospital where employee was sent by you for treatment
- Place/address accident occurred*
- Employee date of hire*

**Not required, but preferred*

A PDF version of the DWC-1 form that can be completed electronically is available for your convenienceif you choose to report a claim via email or fax. Please contact your adjuster at **866-688-6442** to get a copy of this form.

First Fill Form

Client Name: Normandy Insurance

1. Instructions for the **EMPLOYER**:

   - Provide this form to your injured worker to have any prescription filled for up to **7** Days, and please fill out the information below:

Injured Worker Name: **SS#:**
Injured Worker DOB: **Injured Worker Phone:**
Injured Worker Employer: **Date of Injury:**
Injured Worker Address:
City: **State:** **Zip:**

2. Instructions for the **INJURED WORKER** / Instrucciones para el **TRABAJADOR LESIONADO**:

   - **You, the injured worker, will need to bring this form and provide it to the pharmacy along with your prescriptions related to the treatment of your work related injury/illness**
   - **Usted, el trabajador lesionado, deberá llevar este formulario y entregarlo en la farmacia junto con sus recetas relacionadas con el tratamiento de su lesión/enfermedad laboral.**

3. Instructions for the **PHARMACY**:

   - Please submit workers' compensation claims to **S1 Medical** using the following information:

BIN	PCN	Group Id	Member Id
610237	123119	NOR001	Injured Worker SS#

   - Prescription(s) will fill for up to **7 Days.** If there is a remaining balance on the script after it is filled, S1 Medical will call back if and when the balance has been approved. If you need assistance, please call **S1 Medical** at **(888) 356-3332**.

Representative's on-call 24 hours/7 days a week.

FOR ALL REJECTIONS OR QUESTIONS CALL: (888) 356-3332

COMO REPORTAR UNA RECLAMACIÓN – TEXAS

- Una vez que un empleado reporta una lesión o una enfermedad, proporciónele instrucciones sobre cómo obtener atención médica
  - **En caso de emergencia, marque el 911** o lleve al empleado al hospital, sala de emergencias o centro médico más cercano
    En una situación que no sea de emergencia, el empleado debe ser dirigido a un centro de atención urgente (urgent care) o ambulatorio (walk-in) que usted haya seleccionado de esta lista de proveedores localizada en el siguiente enlace: **https://search.primehealthservices.com/Search**

  - Contacte al proveedor/centro médico para informarles que se va a enviar a un empleado para que reciba tratamiento y que se debe realizar una prueba de drogas al empleado lesionado

- Para informar de un accidente, **notifique a Normandy Insurance INMEDIATAMENTE (en un plazo de 24 horas) a través de:**
  - Por teléfono, **al 833-968-7462 (833-YOURNIC)** (este es el método preferido para notificar un accidente), o
  - Envíe por correo electrónico el primer informe de lesión o enfermedad del empleador*[DWC FORM-001 Rev. 10/05*] diligenciado a compcare@normandyins.com; o
  - Envíe por fax el Primer Informe de Lesión o Enfermedad del Empleador*[DWC FORM-001 Rev. 10/05*] diligenciado **al 833-770-1220**
  - - La notificación inmediata de un accidente puede ayudar a reducir el coste del mismo
  - La sección 409.005 de la Ley de Compensación de los Trabajadores de Texas exige que se presente un Primer Informe de Lesión o Enfermedad del Empleador*[DWC FORM-001 Rev. 10/05*] a la Compañía de Seguros de Compensación de los Trabajadores a más tardar el octavo día después de la recepción de la notificación de la enfermedad profesional, o el primer día de ausencia del empleado del trabajo debido a lesión o muerte.
  - Su empresa podría ser multada por el Estado por no comunicar un accidente a su aseguradora

- Si se produce una muerte u hospitalización relacionada con el trabajo de uno o más empleados, debe notificar a la OHSA **en un plazo de 8 horas**, y cada hospitalización relacionada con el trabajo, así como las amputaciones y pérdidas de un ojo deben notificarse a la OSHA **en un plazo de 24 horas**. La normativa de notificación afecta a todos los empleadores cubiertos por la OSHA, incluso a los que están parcialmente exentos de mantener registros de lesiones y enfermedades
  - La Administración de Seguridad y Salud Ocupacional (OSHA) de su estado llamando al número de teléfono central gratuito de la OSHA, 1-800-321-OSHA (1-800-321-6742). O bien mediante el envío electrónico a través de la aplicación de notificación que se encuentra en el sitio web público de la OSHA en **www.osha.gov**.
- Hacer que el empleado lesionado y el supervisor y/o los testigos completen un formulario de Informe de Investigación de Accidentes
  - **NOTA**: **Si no está de acuerdo con la descripción del accidente o cree que no se ha producido un accidente, usted sigue estando obligado a informar del incidente a Normandy. Es imperativo que se reporte un accidente, aunque éste sea dudoso.**

NORMANDY INSURANCE COMPANY

- Mantenga un contacto continuo con el empleado lesionado para hacerle saber que usted se preocupa por su bienestar y que el trabajo está disponible. Si el médico tratante autoriza a un empleado a volver al trabajo en una capacidad de trabajo alternativo, usted debe intentar hacer los ajustes necesarios para que el empleado lesionado vuelva a su lugar de trabajo.

- Usted puede esperar tener noticias de parte de su ajustador dentro de las 24 horas de haber reportado un accidente y también durante la duración de la reclamación, pero es importante que usted también se mantenga en contacto con su ajustador.

- Proporcione a su ajustador cualquier información pertinente que pueda tener con respecto a sus reclamaciones

- Si un empleado necesita más tratamiento médico por la misma lesión o tiene problemas con los pagos de las reclamaciones, indíquele que se ponga en contacto con su ajustador en el 866-688-6442.

- Para más información, por favor visite **www.normandyins.com**.

Instrucciones para reporte de reclamaciones

Para Reportar un Accidente:

Teléfono: 833-968-7462 (833-YOURNIC)

En línea: www.normandyins.com

Email: compcare@normandyins.com

Fax: 833-770-1220

REPORTAR POR VÍA TELEFÓNICA:

Si se reporta por vía ***TELEFÓNICA***, la operadora que contesta el teléfono hará preguntas en relación con el accidente. También obtendrá algunos datos personales del trabajador lesionado que son necesarios para presentar una reclamación de indemnización por accidente de trabajo.

Si es necesario, ese operador pondrá en contacto a la persona que llama con el ajustador para obtener información respecto del médico y lugar de tratamiento. Si la llamada se realiza fuera del horario de atención al público, el operador proporcionará la información del médico.

REPORTE POR FAX O CORREO ELECTRÓNICO:

Si se reporta por ***FAX*** o ***EMAIL***, los accidentes deben notificarse en el **formulario estatal DWC-1, First Report of Injury or Illness** form**.** La siguiente información es necesaria para presentar la reclamación:

- Nombre completo, dirección y número de teléfono del trabajador lesionado
- Ocupación, fecha de nacimiento, sexo del empleado lesionado
- Número de Seguridad Social del trabajador lesionado
- Fecha y hora del accidente
- Descripción del accidente por parte del empleado
- Lesión/enfermedad ocurrida, parte del cuerpo lesionada
- Nombre de la empresa, teléfono, dirección y número de póliza, si se conoce
- La dirección del empleador es diferente a la anterior
- ¿El empleado volvió a trabajar? Si es así, anote la fecha.
- ¿Está usted (el empleador) de acuerdo con el accidente?
- Nombre del médico u hospital al que fue enviado el empleado para su tratamiento
- Lugar/dirección donde ocurrió el accidente*
- Fecha de contratación del empleado*

**No es necesario, pero sí preferible*

Para su comodidad, existe una versión en PDF del formulario DWC-1 que puede diligenciar electrónicamente si decide reportar un accidente por correo electrónico o fax. Por favor, póngase en contacto con su ajustador en **el 866-688-6442** para obtener una copia de este formulario.

First Fill Form

Client Name: Normandy Insurance

1. Instructions for the **EMPLOYER**:

   - Provide this form to your injured worker to have any prescription filled for up to **7** Days, and please fill out the information below:

Injured Worker Name: **SS#:**
Injured Worker DOB: **Injured Worker Phone:**
Injured Worker Employer: **Date of Injury:**
Injured Worker Address:
City: **State:** **Zip:**

2. Instructions for the **INJURED WORKER** / Instrucciones para el **TRABAJADOR LESIONADO**:

   - **You, the injured worker, will need to bring this form and provide it to the pharmacy along with your prescriptions related to the treatment of your work related injury/illness**
   - **Usted, el trabajador lesionado, deberá llevar este formulario y entregarlo en la farmacia junto con sus recetas relacionadas con el tratamiento de su lesión/enfermedad laboral.**

3. Instructions for the **PHARMACY**:

   - Please submit workers' compensation claims to **S1 Medical** using the following information:

BIN	PCN	Group Id	Member Id
610237	123119	NOR001	Injured Worker SS#

   - Prescription(s) will fill for up to **7 Days.** If there is a remaining balance on the script after it is filled, S1 Medical will call back if and when the balance has been approved. If you need assistance, please call **S1 Medical** at **(888) 356-3332**.

Representative's on-call 24 hours/7 days a week.

FOR ALL REJECTIONS OR QUESTIONS CALL: (888) 356-3332

Prime Health Services TX HCN - Employee Notice Delivery & Acknowledgment Form Log

Use this log to record your delivery of the Notice of Network Requirements to employees and their signatures of the Network Acknowledgment Form.

Employer Name: ______________________________

Notice of Network Requirements							Employee Acknowledgment Form	
Initial/ Post-Injury	Employee ID#	Last Name, First Name	Delivery Method (paper, electronic)	Recipient	Location (home, business, other)	Delivery Date	Acknowledgment Form Signed or Refused	Signed/Refused Date

Prime Health Services Texas Health Care Network

Employee Notice of Network Requirements

-

To contact Prime Health Services or to locate a network provider, call us toll-free at 877-325-1253 or use our online provider search tool at https://normandyinsurance.primehealthservices.com/Search.

PRIME HEALTH SERVICES

Texas HCN – Employee Rights and Obligations

Dear Employee:

Your employer selected the Prime Health Services Texas HCN as the certified workers' compensation network that will manage your health care if you have a work-related injury. Our provider network is dedicated to delivering quality treatment that will allow you to return to work quickly and safely. By following the instructions in this packet, you can help ensure that you will not have to pay the bill for the medical care you receive while treating your injury.

While your employer works hard to assure your workplace safety, we work with your employer to make sure you are given the important information in advance that will help you seek the proper treatment for a work-related injury. If you are injured at work, you will receive this information again along with access to a current list of our in-network providers.

If your injury is a life-threatening emergency, go to the nearest emergency room.
If your injury is NOT a life-threatening emergency, then you should:

- Tell your supervisor immediately about your work-related injury.
- Refer to this packet for your rights and obligations when seeking treatment for your injury.
- Ask your employer to assist you in locating a network treating doctor.
- You may also contact Prime Health Services for questions about treating your injury through our network or if you need assistance locating a network provider.

Prime Health Services, Inc.
Attn: TX HCN Support
331 Mallory Station Road
Franklin, TN 37067
866-348-3887

After you are injured on the job

You must select a treating doctor

If you live within the network service area, you must select a treating doctor to oversee the healthcare you receive for your injury. (Please refer to the map on page eight (8) to see if you live in one of the 250 counties in our service area).

For emergency services, you must obtain all healthcare and specialist referrals through your treating doctor. This is important because our providers have agreed to look only to the network — and not to employees — for payment to treat work-related injuries. If you are treated by someone who is not an in-network provider without prior approval from Prime Health Services, then you may have to pay your medical bill.

How to select a treating doctor

You must select your treating doctor from a list of doctors in the Prime Health Services network OR you have the option to choose your current primary care physician to act as the treating doctor for your workers' compensation claim. If you had a primary care physician prior to your injury and wish to select that physician as your treating doctor, you must request approval from Prime Health Services by calling 1-866-348-3887. Your current physician must agree to the terms of our network contract and agree to abide by all applicable laws and regulations before being approved to act as your treating doctor. If your current physician is not approved, or if you decide to change doctors in the future, then you must select an in-network treating physician.

Contact your employer / adjustor for a current provider listing or you may access it through our website at www.primehealthservices.com. A printed copy is available upon request. The list is updated at least every three (3) months and identifies treating providers who are accepting new patients. You may also call us toll-free at 1-866-348-3887 if you need assistance.

If you are injured at work after normal business hours or while working outside the service area, you should go to the nearest care facility. However, if it is not an emergency and you go to an out-of-network provider, you may be responsible for paying the bill for the services you received.

If you need emergency care

Emergency care does not need to be approved in advance. Under Texas Law, "emergency" is defined as either a medical or mental health emergency. A "medical emergency" is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the

absence of immediate medical attention could reasonably be expected to result in either (i) placing the patient's health or bodily functions in serious jeopardy; or (ii) the serious dysfunction of any body organ or part. A "mental health emergency" is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or to another person.

If you are injured and it is an emergency, call 911 or go to the nearest emergency room. After you receive emergency care, you may need ongoing care. If so, you must select a treating provider from our network to oversee the rest of the healthcare you receive for your injury.

You may see out-of-network providers and still be eligible for coverage of your costs only if:

- Emergency care is needed; or
- You do not live within the network service area; or
- Your treating doctor refers you to an out-of-network provider and it was approved in advance; or
- You chose your primary care physician and he / she was approved by the network after agreeing to abide by the network contract and applicable laws.

Referrals and Specialists

You do not need a referral if you have an emergency health condition. Except for emergencies, your treating doctor will provide all of your care and will make all referrals to specialists where needed. Healthcare services, including referrals, will be made available to you on a timely basis according to your medical condition, but no more than 21 days after your request. If you need a specialist that is not available in your area, your treating doctor must get approval from the network before referring you to an out-of-network provider. The network must approve referrals to out-of-
network providers within seven (7) business days after your referral was requested, or sooner if you have a serious health condition that requires faster approval. If the

network denies the referral request, you may appeal the decision through our complaint process detailed in this packet.

To change your treating provider

If we inform you that your treating doctor left the network, you must select another in-network provider. If you have a serious condition in which changing doctors could harm you, your doctor may request that you continue treatment with him / her up to an additional 90 days.

If you are dissatisfied with your first choice of a treating provider, you may select an alternate treating provider from the list of in-network providers in your area. We will not deny your selection of an

alternate in-network provider. However, if you remain dissatisfied, you must have your request approved by the network before changing your treating provider a second time.

Service area review

If you believe you do not currently live within our network service area, you may call Prime Health Services to request a service area review. You will need to provide proof to support your claim. We will send you our decision in writing within seven (7) days after we receive your request.

If you do not agree with our final service area decision, you have the right to file a complaint with the Texas Department of Insurance. Your complaint must include your name, address, telephone number, a copy of our decision, and any evidence you sent to us to review. A complaint form is available on the Department's website at www.tdi.state.tx.us. You may also request a form by writing to:

HMO Division, Mail Code 103-6A,
Texas Department of Insurance
P. O. Box 149104
Austin, TX 78714-9104.

If you assert that you do not currently live in the service area, you may want to receive treatment from our in-network providers while you wait for our review or while you wait for the Department to review your complaint. If it is ultimately determined
that you live within our service area, then you may have to pay for any healthcare you received from out-of-network providers.

Treatment needing advanced approval

Treatment prescribed by your provider may need to be approved in advance. You, or your provider, are required to request approval from the network for the services listed below before they are provided to you. You may continue to need treatment after you receive the approved services. For example, if you need to stay in the hospital longer than the time period that was first approved. If so, the additional treatment must be approved by the network in advance as well.

The following are treatments and services that need advance approval from the network:

- All surgeries, including inpatient and outpatient, or ambulatory surgical services;
- Any inpatient admission, including the principal scheduled procedures and length of stay;
- All non-exempted work hardening or non-exempted work conditioning programs;
- Physical and occupational therapy services, and rehabilitation or dependency programs;
- Psychological or psychiatric services or testing after the initial evaluation;

- An experimental service / test not yet broadly accepted as the prevailing standard of care;
- All MRI and CT scans and repeat individual diagnostic studies;
- All DME in excess of $500 per item (rental or purchase);
- Chronic pain management or interdisciplinary pain rehabilitation;
- Drugs not included on the Division's formulary;
- Treatments and services that exceed or are not addressed by the adopted treatment guidelines or protocols and are not contained in a preauthorized treatment plan;
- Required treatment plans; and
- Any treatment for an injury or diagnosis that is not accepted by the network pursuant to Labor Code §408.0042 and Texas Administrative Code §126.14.

If the network denies your request for treatment, we will send you a written notification and inform you of your right to request a reconsideration of the denied treatment or request a review by an Independent Review Organization through the Texas Department of Insurance.

Complaints

If you are dissatisfied with any aspect of the network's operations, including complaints about in-network providers, you may file a complaint with Prime Health Services. You must notify our Grievance Coordinator of a complaint by phone or in writing via mail, email, or fax no later than 90 days from the date the issue occurred. Forward your complaints to:

Prime Health Services Texas HCN
Attention: Grievance Coordinator
331 Mallory Station Road
Franklin, TN 37067
Phone: 866-348-3887 Fax: 615-329-4751
grievance.coordinator@primehealthservices.com

Texas law does not permit Prime Health Services to retaliate against you or your employer if you or your employer files a complaint against the network. In addition to that, Prime Health Services cannot retaliate if you or your employer appeals the decision of the network. The law does not permit the network to retaliate against your treating provider if he / she files a complaint against the network or appeals the decision of the network on your behalf.

Upon receiving your complaint, Prime Health Services will send you an acknowledgement letter within seven (7) business days. The letter will describe the network's complaint procedures and deadlines. We

will review and resolve your complaint in writing within 30 days of receipt of the request. To avoid delay, please include your name, address, telephone number, a copy of the network's prior decision (if any), and any evidence you had sent to us to review or now want us to review.

You also have the right to file a complaint with the Texas Department of Insurance if you disagree with a determination made by the network. The Department's complaint form is available on its website at www.tdi.state.tx.us or by calling 800-252-7031, or you may request a form by writing to:

HMO Division, Mail Code 103-6A
Texas Department of Insurance
P. O. Box 149104
Austin, TX 78714-91047

If you send a complaint to the Department, it must include your name, current mailing address, telephone number, a copy of the network's decision, and any evidence you sent to the network to review.

Adverse determination, reconsiderations, & independent review

If you are notified of an adverse determination by the network, this notification will include:

- Principal reasons and clinical basis for the adverse determination;
- Description of or source of the screening criteria used as guidelines;
- Professional specialty of any provider consulted;
- Description of the reconsideration process and availability of independent review.

If you receive notification of an adverse determination based on medical necessity, you may request an independent review through the Texas Department of Insurance. Forms related to the availability of an independent review may be obtained from the Department's website at www.tdi.state.tx.us, or by writing to:

HMO Division, Mail Code 103-6A
Texas Department of Insurance
P. O. Box 149104
Austin, TX 78714-91047

An employee with a life-threatening condition is entitled to an immediate review by an Independent Review Organization and is not required to comply with the procedures for a reconsideration of an adverse determination (described below).

You (or the person acting on your behalf) may request the network to reconsider an adverse determination. Your request can be made by calling or writing the Prime Health Services Grievance Coordinator via the contact information listed below, but you must contact the network to request a reconsideration no later than 30 days after you receive an adverse determination.

Prime Health Services Texas HCN
Attention: Grievance Coordinator
331 Mallory Station Road
Franklin, TN 37067
Phone: 866-348-3887 Fax: 615-329-4751
grievance.coordinator@primehealthservices.com

Within five (5) calendar days after receiving your reconsideration request, the person performing the reconsideration will send you a letter showing the date the request was received and a list of documents that you must submit to complete the reconsideration.

After the reconsideration of your adverse determination is complete, the network will send you (or the person acting on your behalf) a response letter no later than 30 days after your request was received. The letter will explain the resolution and will include the following:

- Specific medical or clinical reasons for the resolution;
- Medical or clinical basis for the decision;
- Professional specialty of any provider consulted and states in which the provider is licensed; and
- Notice of the requesting party's right to seek review of the denial by an Independent Review Organization and the procedures for obtaining that review.

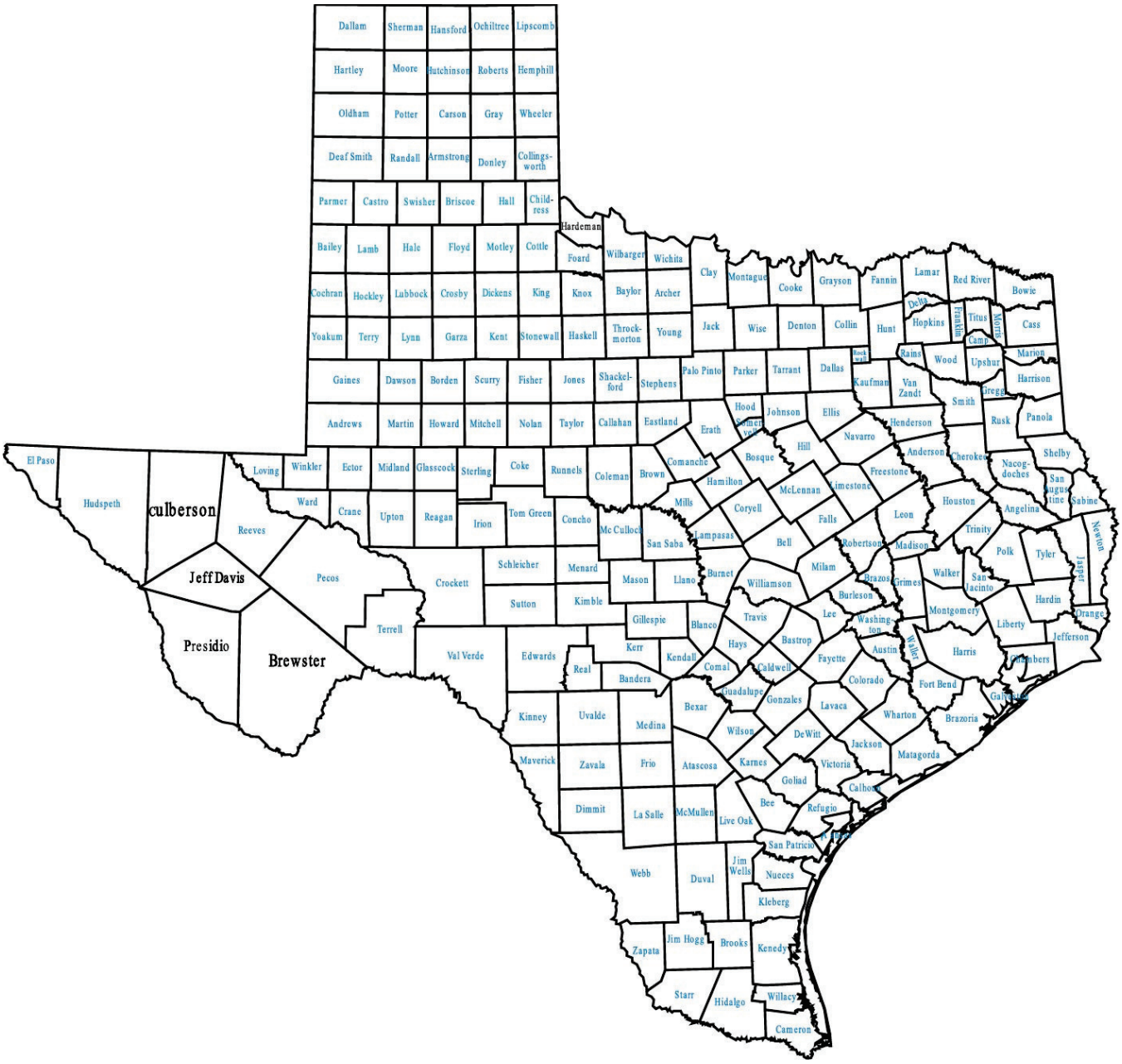
If your referral request is denied because the referral is not medically necessary, or if your request is denied because it is a deviation from treatment guidelines, individual treatment protocols or screening criteria, you (or the person acting on your behalf) are allowed to seek review of the denial by an Independent Review Organization. Please note that you must timely file a request for an independent review no later than 45 days after the date the network denied your reconsideration.

The network must pay for the independent review, and the network is liable for your healthcare while you wait for the results of your appeal. The network, insurance carrier, and employer must comply with the decision made by the Independent Review Organization.

Prime Health Services Texas HCN
Service Area Map

KEY: Service Area – 250 Counties in blue, excludes four counties in black.

PRIME HEALTH SERVICES



PRIME
HEALTH SERVICES

Employee Acknowledgment of Workers' Compensation Network

By signing this form, I acknowledge and understand the following:

- I received the packet of information that tells me how to receive health care services through my employer's workers' compensation insurance.
- If I am hurt on the job and live in the service area described in the packet, I must choose an in-network provider from a list of providers in the Prime Health Services Network, or I may ask my primary care physician to act as my treating doctor. If I select my primary care physician, I will call 866-348-3887 to notify Prime Health Services of my choice.
- I must go to my treating doctor for all healthcare for my injury. If I need a specialist, my treating provider will refer me. If I need emergency care, I may go anywhere.
- An insurance carrier will pay my treating provider and other network providers.
- I might have to pay the bill if I get healthcare, other than emergency care, from someone other than an in-network provider without the network's approval.

_____

Signature Date

_____

Printed Name

_____

Home Address

_____

City State Zip Code

_____

Name of Employer

Name of Network: **Prime Health Services Texas HCN**

Call Prime Health Services toll-free at 866-348-3887 if you need to locate an in-network treating provider.

Please indicate whether this is the:

☐ Initial Employee Notification (no injury involved); or

☐ Injury Notification (date of injury: ___ / ___ / ____)

RETURN THIS FORM TO YOUR EMPLOYER. DO NOT SEND TO PRIME HEALTH SERVICES.

La Red de Salud de Texas de Prime Health Services

Aviso a los Empleados sobre los Requisitos solicitados por la Red

Para contactar Prime Health Services, Inc. o para localizar un proveedor, llame gratis al número telefónico 877-325-1253 o utilice nuestra herramienta de búsqueda en línea en https://normandyinsurance.primehealthservices.com/Search.

Texas HCN – Derechos y Obligaciones del Empleado

Estimado Empleado:

Su empleador ha seleccionado a Prime Health Services Texas HCN como la red de compensación para empleados certificados que manejara su servicio de salud en caso de que Usted sea sujeto de cualquier tipo de daño relacionado en exclusiva con su trabajo. El proveedor seleccionado está dedicado a suministrar tratamiento de calidad lo que le permitirá ser atendido con prontitud y retornar a su trabajo de manera rápida y segura. Siguiendo las instrucciones determinadas en el presente documento, Ud. tendrá por seguro que Ud. no tendrá que pagar la cuenta por cualquier tipo de servicio médico que Ud. reciba mientras su accidente es tratado.

Mientras su empleador se asegura de que su sitio o lugar de trabajo es totalmente seguro, nosotros trabajamos en conjunto con su empleador para asegurarnos que Ud. recibió de manera previa la información que lo guiara y ayudara a buscar el tratamiento adecuado en caso de un accidente laboral. Si Ud. es sujeto de un accidente de trabajo, Ud. recibirá de nuevo la información proveída por el presente documento junto con el acceso a una lista actual de proveedores anexos a la red.

Si su accidente es una emergencia que amenaza con su vida, diríjase al establecimiento de emergencias más cercano. Si su accidente no pone en riesgo su vida, Ud. deberá:

- Contacte a su supervisor inmediatamente y coméntele acerca del accidente del que fue sujeto.
- Diríjase al presente paquete para conocer sus derechos y obligaciones al momento de buscar tratamiento para su accidente.
- Solicítele a su empleador que le colabore en contactar a un doctor de la red para que provea tratamiento.
- Así mismo, Ud. deberá contactar Prime Health Services ante cualquier duda o pregunta acerca del tratamiento proveído por medio de nuestra red o si Ud. necesita ayuda localizando a un proveedor de nuestra Red.

Prime Health Services, Inc.
Attn: TX HCN Support
331 Mallory Station Road
Franklin, TN 37067
866-348-3887

Luego de ocurrido su accidente laboral

Ud. tiene que seleccionar un médico de cabecera

Si Ud. esta domiciliado dentro de una red de servicio, Ud. debe seleccionar un médico de cabecera para que supervise el tratamiento médico adecuado para su accidente laboral. (Por favor diríjase al mapa ubicado en la página 8 con el fin de verificar si Ud. esta domiciliado en alguno de los 250 condados de nuestra red de servicio.) Excepto para servicios de emergencia, Ud. deberá obtener todo tratamiento médico y la remisión especialista a través de su médico de cabecera. Esto es importante porque nuestros proveedores de servicio han acordado solo utilizar la red de servicios – y no para empleados – para pagar el tratamiento de accidente del trabajo. En caso de que Ud. sea tratado por alguien que no pertenece a la red de doctores sin autorización por parte de Prime Health Services, Ud. estará obligado a pagar sus servicios médicos.

Como seleccionar a un Doctor para su tratamiento

Ud. debe seleccionar a un Doctor de la lista de doctores proveída por la red Prime Health Services O Ud. tiene la opción de seleccionar su médico de cabecera para quien actuara en calidad doctor que provea tratamiento a su accidente para el reclamo de su compensación laboral. En caso de que Ud. tenga un médico de cabecera que atienda su accidente laboral y desea seleccionarlo como el Doctor que le proveerá tratamiento, Ud. deberá obtener autorización por parte de Prime Health Services llamado al número telefónico 866-348-3887 (Llamada Gratuita). Su médico de cabecera deberá consentir y estar de acuerdo con los términos de nuestro contrato de red y estar de acuerdo en estar sujeto con todas las regulaciones y leyes aplicables antes de ser autorizado para que actúe como médico de cabera de su accidente. Si su médico de cabecera no es autorizado o Ud. decide cambiar los médicos a futuro, en consecuencia Ud. debe seleccionar un doctor proveído por la red.

Si Ud. Necesita Tratamiento Emergencia

El tratamiento emergencia no necesita ser aprobado con anterioridad. Bajo la ley de Texas, “emergencia” es definida como ya sea una emergencia médica o mental. Una “emergencia médica” es el inicio repentino de una condición médica manifestada por medio de síntomas precisos de suficiente severidad, como incluyendo dolor severo, que la falta de atención médica inmediata razonablemente esperada resulte en (i) en colocar en extremo peligro la salud del paciente o sus funciones motoras; o (ii) la disfunción de cualquier parte u órgano del cuerpo. Una “emergencia mental” es una condición que razonablemente represente un peligro para la condición mental de la persona que la sufre u otra persona que la experimente.

Si Ud. se encuentra lesionado y es una emergencia, llame al 911 o diríjase al lugar más cercano de atención emergencias médicas. Después de que Ud. reciba atención de emergencia y en caso de que Ud. requiera tratamiento continuo, Ud. deberá seleccionar uno de los doctores de nuestra red para que supervise su tratamiento médico recibido con ocasión de su accidente laboral.

Ud. podrá no optar por seleccionar uno de nuestros proveedores de servicio y tener cobertura de los costos médicos en que Ud. incurrió solo sí:

- La emergencia médica es necesitada; o

- Ud. no está domiciliado en una área de servicio; o
- Si su médico de cabecera lo remite una red de servicio ajena a nuestros proveedores y esta fue aprobada antes de su remisión; o
- Ud. seleccionó su médico de cabecera y este fue autorizado por nuestra red después de que este aceptó someterse a nuestro contrato de red y sus leyes aplicables.

Remisiones y especialistas

Ud. no necesita una remisión si tenga una condición de emergencia de salud. Excepto para emergencias, su doctor de cabecera proveerá todo tratamiento y hará todas las remisiones necesarias. Los servicios de atención en salud, incluyendo las remisiones, lo habilitarán oportunamente acorde con su condición médica, pero no más de 21 días después de su solicitud. Si Ud. necesita una especialista y este no se encuentra habilitado en su área, su médico de cabecera deberá obtener una autorización previa antes de su remisión a proveedor fuera la red. La red deberá aprobar las remisiones a proveedores fuera de la red dentro de los di este días siguientes a la solicitud interpuesta, o lo más pronto posible si Ud. tiene condiciones serias de salud que ameriten una aprobación inmediata. Si la red no aprueba la remisión peticionada, Ud. tendrá el derecho de apelar la decisión a través de nuestro servicio de quejas debidamente detallado en este paquete.

Para cambiar su médico de cabecera

Si somos informados que su doctor de cabecera abandono nuestra red, Ud. deberá seleccionar otro doctor de la base de datos de doctores de la red. En caso de que Ud. tenga una condición seria de salid en la cual el cambio de doctores pueda afectarlo, su doctor podrá solicitar que Ud. continúe su tratamiento con él/ella hasta un término adicional de 90 días.

Si Ud. se encuentra insatisfecho con el primer médico de cabecera seleccionado, Ud. podrá seleccionar otro medio de la base de datos de doctores proveída por la red. Nosotros no denegaremos este cambio. Sin embargo, si Ud. se mantiene inconforme, Ud. deberá tener una petición previamente aprobada por la red antes de cambiar su doctor de cabera una segunda vez.

Revisión del Área de Servicio

En caso de que Ud. considere que actualmente no se encuentra domiciliado dentro de una red de servicio, Ud. podrá comunicarse con Prime Health Services para solicitar una revisión de las áreas de servicio en su zona. Ud. necesitará presentar prueba que soporte su reclamo. Nosotros le enviaremos nuestra decisión por escrito dentro de los 7 días siguientes a la recepción de tu petición.

En caso de que Ud. no se encuentre de acuerdo con nuestra decisión, Ud. tiene derecho para presentar una queja ante el Departamento de Seguros de Texas. Su queja deberá incluir su nombre, dirección de residencia, número telefónico, una copia de nuestra decisión, y cualquier tipo de documentación relacionada con dicha queja. Los formatos de queja se encuentran habilitados en la página web del

Departamento de Seguros de Texas https://www.tdi.texas.gov Adicionalmente, Ud también podrá solicitar un formato de queja escribiéndonos a:

HMO Division, Mail Code 103-6A,
Texas Department of Insurance
P. O. Box 149104
Austin, TX 78714-9104.

En caso de que Ud. afirme que Ud. actualmente no está domiciliado/a en un área de servicio y Ud. podrá recibir tratamiento médico por parte por parte de alguno de nuestros proveedor de red mientras Ud. espera nuestra decisión sobre la revisión o mientras Ud. se encuentra a la espera de una decisión del Departamento de Seguros de Texas ante la queja presentada. En caso de que sea determinado que Ud. se encuentra domiciliado dentro de una de nuestras áreas de servicio, Ud. deberá pagar por todos y cada uno de los tratamientos médicos que haya recibido por parte de los doctores y redes ajenas a nuestros prestadores de servicio.

Autorización de Tratamiento Médico Previo

El tratamiento médico ordenado por el médico de cabecera deberá ser autorizado con anterioridad. Ud. (o su Doctor) tiene el deber de presentar una petición para aprobación por parte de la red para los servicios enlistados en la parte inferior ANTES de que le sean suministrados o proveídos. Ud. podrá continuar recibiendo su tratamiento después que sea aprobada su solicitud de servicios; por ejemplo, en caso de que Ud. necesite estar hospitalizado por un término mayor del tiempo que había sido aprobado en primera medida, Ud. necesitará que su tratamiento sea aprobado por parte de la red con anterioridad.

Los siguientes son los tratamientos y servicios que deberán ser aprobados con anterioridad:

- Cualquier tipo de cirugía, incluyendo hospitalización o servicios ambulatorios quirúrgicos.
- Cualquier tipo de admisión a hospitalización, incluyendo los procedimientos agendados y a lo largo de la hospitalización.
- Todos los programas de rehabilitación laboral no exentos y todos los programas de rehabilitación de acondicionamiento laboral no exentos.
- Servicios de terapias físicas y ocupacionales y relacionadas con los programas de rehabilitación o dependencia.
- Servicios psicológicos y psiquiátricos o de tratamiento después de la valoración inicial.
- Los servicios o test experimentales no aprobados ampliamente como tratamiento estándar de atención
- Todas las tomografías MRI y CT y todos los estudios de diagnóstico individuales para repetición.
- Todos los DME que superen el valor de $500 por artículo sean rentados o comprados.
- Manejo crónico de dolor o rehabilitación interdisciplinaria para el dolor.

- Todos los medicamentos no incluidos en el formulario de la División.
- Todos los tratamientos y servicios que excedan o que no estén relacionados con las guías y protocolos de tratamiento adoptados y que tampoco estén pre autorizados como plan de tratamiento.
- Planes de tratamiento requeridos; y
- Cualquier tipo de tratamiento por cualquier tipo de lesión o diagnóstico que no es aceptado por la Red de acuerdo con el Labor Code §408.0042 y Texas Administrative Code §126.14.

En caso de que la Red niegue su solicitud de tratamiento, Nosotros le enviaremos una comunicación por escrito informado el de su derecho a presentar una solicitud de reconsideración contra el tratamiento denegado o solicitando una revisión por parte de la Independent Review Organization a través del Departamento de Seguros de Texas.

Quejas

En caso de que Ud. se encuentre insatisfecho con cualquier aspecto relación con la operación de la Red, incluyendo quejas acerca de los doctores, Ud. podrá presentar una queja ante Prime Health Services. Ud. deberá notificar a nuestro Coordinaros de Quejas en caso de que la queja sea presentada via telefónica o enviada vía mail, email, o fax entro de un término no mayor a 90 días contados a partir de la fecha de ocurrencia del inconveniente o disconformidad. Prosiga sus quejas ante:

Prime Health Services Texas HCN
Attention: Grievance Coordinator
331 Mallory Station Road
Franklin, TN 37067
Phone: 866-348-3887 Fax: 615-329-4751
grievance.coordinator@primehealthservices.com

La Ley de Texas no permite que Prime Health Services tome represalias en contra suya o de su empleador, si Ud. o su empleador presenta una queja en contra de la Red. Adicionalmente, Nosotros no podemos adoptar ningún tipo de medida si Ud. o su empleador apela la decisión tomada por la Red. La Ley no permite que la Red tome alguna medida en contra de su médico de cabecera si este presenta una queja en contra de la Red o apela la decisión de la Red en su nombre.

Al momento de recibir su queja, Prime Health Services le enviara una carta de reconocimiento dentro de 7 días. La carta describirá los procedimientos de queja de la Red y los términos. Nosotros revisaremos y resolveremos su queja por escrito dentro de los 30 días siguientes de recibo de la petición. Para evitar cualquier tipo de demora, por favor incluya su nombre, dirección de domicilio, número telefónico, una copia de la primera decisión de la Red (si la hay), y cualquier tipo de evidencia que nos haya enviado para su revisión o toda evidencia que Ud. considere debe ser revisada por nosotros.

Adicionalmente, Ud. tiene el derecho de presentar una queja ante el Departamento de Seguros de Texas si Ud. se encuentra en desacuerdo con la decisión adoptada por la Red. El formulario de quejas del

Departamento se encuentra habilitado en el sitio Web de la misma https://www.tdi.texas.gov o llamando al número telefónico 800-252-7031, o puede presentar una solicitud por escrito a:

HMO Division, Mail Code 103-6A,
Texas Department of Insurance
P. O. Box 149104
Austin, TX 78714-9104.

En caso de que Ud. envié una queja al Departamento, esta deberá incluir su nombre, dirección actual de correo electrónico, número telefónico, una copia de la decisión adoptada por la Red, y cualquier tipo de evidencia que Ud. haya enviado para revisión a la Red.

Decisiones adversas, Reconsideraciones y Revisiones Independientes

Si Ud. es notificado de una decisión adversa por parte de la Red, la notificación pertinente incluirá:

- Las razones principales y el fundamento clínico que soporta la decisión adversa
- Descripción de o la fuente de criterio empleada como guía
- El consejo profesional de un especialista en el área en caso de que allá sido consultado
- Descripción del proceso de reconsideración y la habilitación de una revisión independiente.

Si Ud. recibe notificación de una decisión adversa basada en una necesidad médica, Ud. podrá solicitar una revisión independiente de la misma por medio del Departamento de Seguros de Texas. Los formularios relacionados con la habilitación de una revisión independiente podrá ser obtenidos por medio del sitio web del Departamento https://www.tdi.texas.gov , o por medio de solicitud por escrito ante

HMO Division, Mail Code 103-6A,
Texas Department of Insurance
P. O. Box 149104
Austin, TX 78714-9104.

Un Empleado con una condición que amenaza con su vida tiene el derecho a una revisión inmediata por medio de Independent Review Organization y no estará sujeto a cumplir con los procedimientos para obtener una reconsideración ante una posible decisión adversa (descrita en la parte inferior).

Ud. (o la persona actuando en su nombre) podrá solicitar a la Red reconsiderar una decisión adversa. La petición podrá ser hecha vía telefónica o por escrito ante el Coordinador de Quejas de Prime Health Services por medio de la información de contacto determinada en la parte inferior. Sin embargo, Ud. deberá tener en cuenta que deberá presentar su reconsideración dentro de un término no mayor a 30 días después de que Ud. recibió la decisión adversa:

Prime Health Services Texas HCN
Attention: Grievance Coordinator
331 Mallory Station Road
Franklin, TN 37067
Phone: 866-348-3887 Fax: 615-329-4751
grievance.coordinator@primehealthservices.com

Dentro de los 5 días calendario después de recibida su petición de reconsideración, la persona encargada de resolver la reconsideración le enviara una carta mostrado la fecha en que su petición fue petición fue requerida y la lista de los documentos que Ud. deberá presentar para completar la reconsideración.

Después de que la reconsideración que resuelve la decisión adversa está completa, la Red le eviara a Ud (o a la persona que actúa en su nombre) una carta de respuesta dentro de un término no mayor a 30 días después de que su petición fue recibida. La carta de respuesta explicara la resolución de su caso e incluirá lo siguiente:

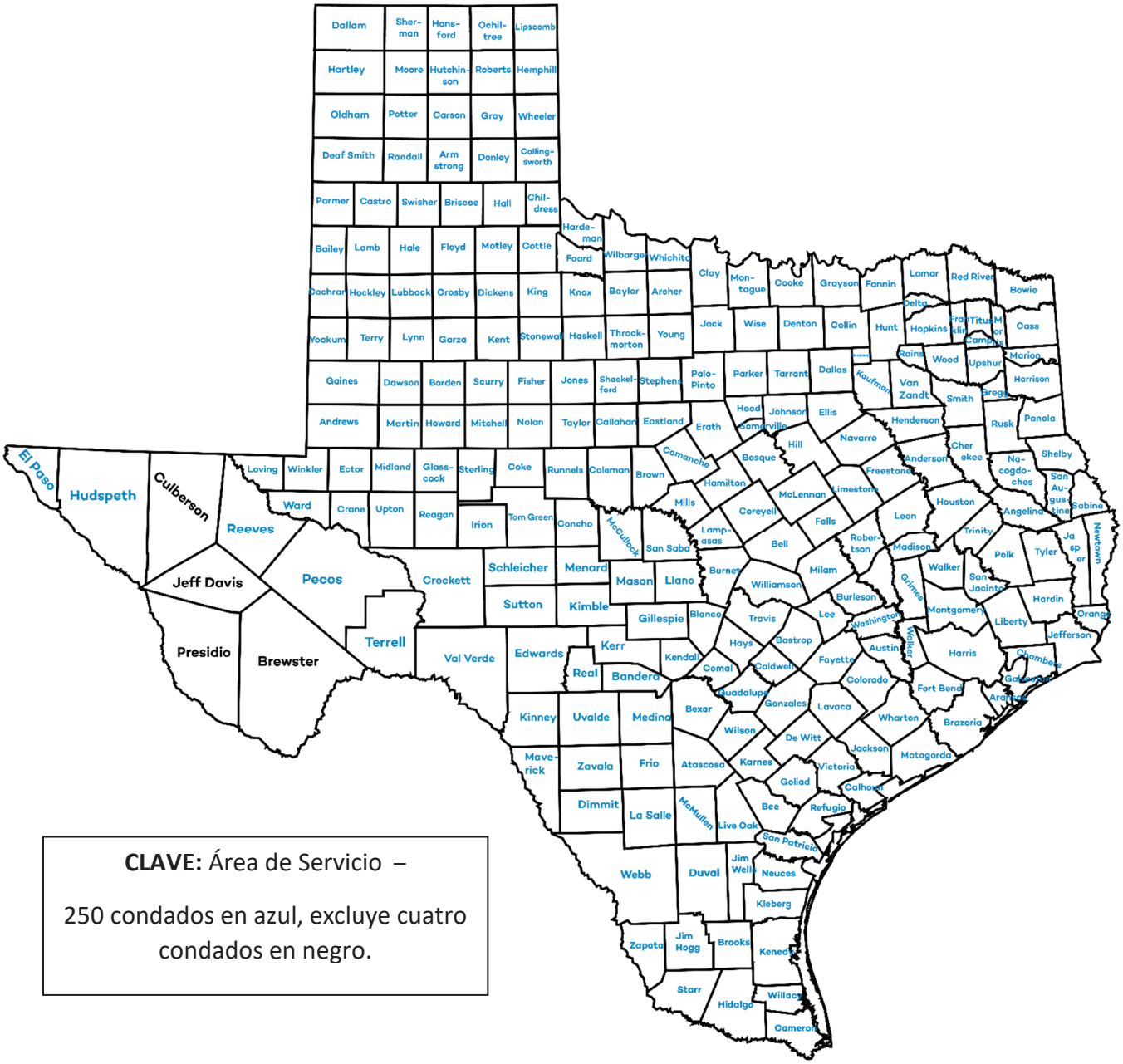
- Las razones médicas y clínicas que fundamentan la resolución
- El fundamento médico y clínico que fundamenta la decisión
- El concepto dado por un especialista del área en caso de que haya sido requerido y el estado en que el especialista consultado esta licenciado; y
- Notificación del derecho de la parte para solicitar o peticionar una revisión de la denegación por medio de una Independent Review Organization y el procedimiento a seguir para obtener una revisión.

Si su solicitud de remisión es denegada porque la remisión mediamente no resulta necesaria, o si su solicitud es denegada porque constituye una desviación de la guía de tratamiento, de los protocolos de tratamiento individuales o el criterio establecido, Ud. (o la persona que actúe en su nombre) tienen el derecho a buscar la revisión de la denegación por medio de una Independent Review Organization. Por favor, tenga en cuenta que Ud. debe oportunamente presentar una petición para una revisión independiente dentro del término no mayor a 45 días luego de la fecha en que la Red negó su solicitud de reconsideración.

La Red está obligada a pagar los costos de la revisión independiente, y la Red será responsable por el cuidado de su salud mientras Ud. espera los resultados de su apelación. La Red, el corredor de seguros, y el empleador están obligados a cumplir con la decisión adoptada por la Independent Review Organization.

PRIME HEALTH SERVICES

Prime Health Services Texas HCN
Mapa del Área de Servicio



CLAVE: Área de Servicio –

250 condados en azul, excluye cuatro condados en negro.

PRIME HEALTH SERVICES

Reconocimiento otorgado por parte del Empleado acerca de la Red de Compensaciones de los Trabadores

Al firmar de este formulario, Yo reconozco y entiendo que:

- He recibido el paquete de información que me comunica y dice como recibir y obtener tratamientos de un médico del seguro de compensación para trabajadores de mi empleador.
- En caso de que sufra un accidente en el trabajo y viva en el área descrita en el paquete, estoy obligado a seleccionar un médico de la base de Doctores proveída en la red por Prime Health Services, o puedo preguntarle a mi médico de atención primaria si puede actuar como mi médico tratante. En caso de que seleccione a mi primer médico tratante, estoy obligado a comunicarme vía telefónica al número 866-348-3887 (Línea Gratuita) con el fin de notificar a Prime Health Services, de mi elección.
- Estoy obligado a ir a mi médico tratante para toda la atención de mi salud para mi lesión. Si necesito un especialista, mi doctor me referirá. Si necesito atención de emergencia, puedo ir a cualquier parte.
- La compañía de seguros le pagara a mi médico tratante y a los proveedores de servicios médicos de la red.
- Es posible que tenga que pagar la factura si recibo atención médica, aparte de la atención de emergencia, de alguien que no sea un médico de la aprobación de la red.
- Sabiamente hacer falsas reclamaciones de compensación de los trabajadores, puede dar lugar a investigaciones penales que podrían dar lugar a sanciones penales como multas y encarcelamiento.

_____

Firma Fecha

_____

Nombre

_____

Dirección de Domicilio

_____

Ciudad Estado Código Zip

_____

Nombre Empleador

Nombre de la Red: Prime Health Services Texas HCN

Si necesarita localizar un médico para su tratamiento, llame Prime Health Services al número telefónico 866-348-3887. Por favor, indique si:

☐ La notificación inicial como empleado (ninguna lesión ocasionada); o

☐ notificación de accidente laboral (fecha de accidente laboral): ____/___/ ____)

mes día año

Devuelva este formulario a su empleador. No lo envíe a Prime Health Services

PRIME HEALTH SERVICES

Workers' Compensation Health Care Network

Employer Welcome Packet

Dear Employer:

Welcome to the Prime Health Services Texas HCN. This packet includes important information to assist you and your employees as you begin accessing our network for your workers' compensation healthcare needs. This two-page Employer Welcome Packet lists the actions for which you (as the employer) are responsible. Please ensure that you do all of the following:

Initial Steps for Employers:

- Distribute the nine (9)-page ***Employee Notice of Network Requirements*** (the "Notice") to current employees in English, Spanish, or any other language common to your employees. If you need it in another language, call 866-348-3887 or it is available at www.primehealthservices.com.
- Post the Notice at each business location (for example, near OSHA or minimum wage postings).
- Be sure to give the Notice to new employees within three (3) days of hire.
- *Signature Requirement* After you supply a written copy of the Notice or a way to access a written copy (such as an email attachment), ask employees to sign the ***Acknowledgment Form,*** found on page nine (9), either physically or electronically**,** of the Notice to show they received the information.
- Establish a standard process for delivering the Notice to employees and document the following:
  - Employee name and Date of Delivery;
  - Location of Delivery – *(delivered to their home or work address)*;
  - Delivery Method – *(as part of a "new hire" packet, at a staff or safety meeting, email, etc.)*

Note: According to the Texas Department of Insurance, if you fail to establish a process that documents the above five items, it creates the presumption that your employees did not receive the Notice. To assist you, we have a sample ***Delivery Log*** on our website that you can use, or you may use any other documentation method that meets the above requirements.

- Retain your employees signed Acknowledgment Forms and please DO NOT return them to Prime Health Services unless we specifically request a copy at the time of injury. An employee

who refuses to sign the form remains subject to the network requirements. Simply document the employee's refusal in their personnel file, and try to have a witness available.

An injured employee may be allowed to seek care from a non-network treating doctor if you fail to provide a Notice and obtain a signed Acknowledgment Form within the required timeframe.

If an Employee is Injured on the Job:

After an employee is injured on the job, please ensure that you take the following actions:

- Whenever possible, assist the injured employee by arranging / providing their transportation to a network provider, or if necessary, to the nearest emergency facility.
- Within 24 hours of the injury, complete the first report of injury / incident report. You can access the report form online at http://www.primehealthservices.com/state-compliance/tx/, which has instructions for submitting the form via email or fax, or you can call us at 866-348-3887.
- Inform employees of the availability of the network and re-distribute the nine (9) page Employee Notice packet. Assist the employee in locating a network treating doctor. Our provider listing is available through our website or by calling us at 866-348-3887 for assistance in locating available providers in your area.
- Upon being injured, the employee must sign an additional Acknowledgment Form (page 9 of their Notice packet), which is available at http://www.primehealthservices.com/state-compliance/tx/

Please, remember to visit our website at http://www.primehealthservices.com/state-compliance/tx/ where you can view our updates and regulations from the Texas Department of Insurance and download copies of the necessary forms mentioned in this packet, including the following:

- A copy of this ***Employer Welcome Packet***
- The ***Employee Notice of Network Requirements*** (the "Notice")
- A copy of the ***Employee Acknowledgement Form*** (also found on page nine (9) of the Notice)
- A sample ***Delivery Log***

DWC FORM-001
(Employer's First Report of Injury or Illness)

The **employer** is required to file an **Employer's First Report of Injury or Illness** [DWC FORM-001 Rev. 10/05] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

The **Employer's First Report of Injury or Illness** provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. Details of the claimant's employment and circumstances surrounding the injury or illness are also requested.

Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

[Workers' Compensation Rule 120.2]

INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-001)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Section 409.005, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM-001 Rev. 10/05 to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Section 409.006. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.** The Division's Health and Safety will use data from this report for the Job Safety Information System established in Section 411.032 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2,7,8:	Section 402.082, Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
Item 4:	If no home phone, please provide a phone number where the employee can be reached.
Items 5,15,17, 26,29,30:	Enter data in month, day, year format. Example: 08-13-54.
Item 18:	List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.
Item 19:	List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
Item 20:	Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
Item 22:	State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.
Item 24:	List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.
Items 32,33:	Enter date in month-year format. Example: 02-56.
Item 37:	Enter the number of days or hours that make up a full work week for your employees.
Item 45:	Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.
Item 46:	For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)	2. Sex F ☐ M ☐
3. Social Security Number - -	4. Home Phone ( )
5. Date of Birth (m-d-y) - -	
6. Does the Employee Speak English? YES ☐ NO ☐ If No, Specify Language	
7. Race White ☐ Black ☐ Asian ☐	8. Ethnicity Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address Street or P.O. Box	
City State Zip Code County	
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐	
11. Number of Dependent Children	12. Spouse's Name
13. Doctor's Name	
14. Doctor's Mailing Address (Street or P.O.Box)	
City State Zip Code	

15. Date of Injury (m-d-y) - -	16. Time of Injury : am ☐ pm ☐	17. Date Lost Time Began (m-d-y) - -
18. Nature of Injury*	19. Part of Body Injured or Exposed*	
20. How and Why Injury/Illness Occurred*		
21. Was employee doing his regular job? YES ☐ NO ☐	22. Worksite Location of Injury (stairs, dock, etc.)*	
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site Street or P.O. Box County City State Zip Code		
24. Cause of Injury(fall, tool, machine, etc.)*		
25. List Witnesses		
26. Return to work date/or expected (m-d-y) - -	27. Did employee die? YES ☐ NO ☐	28. Supervisor's Name
		29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y) - -	31. Was employee hired or recruited in Texas? YES ☐ NO ☐	32. Length of Service in Current Position Months _____ Years _____	33. Length of Service in Occupation Months _____ Years _____
34. Employee Payroll Classification Code	35. Occupation of Injured Worker		
36. Rate of Pay at this Job $_____Hourly $_____Weekly	37. Full Work Week is: _____ Hours _____ Days	38. Last Paycheck was: $_____ for ___ Hours or _____ Days	39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form	41. Name of Business
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ( ) City State Zip Code	43. Business Location (If different from mailing address) Number and Street City State Zip Code

44. Federal Tax Identification Number	45. Primary North American Industry Classification System Code:(6 digit)	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.
48. Workers' Compensation Insurance Company		49. Policy Number	

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____

Out of Network Provider Request Form

Patient Information:	Patient Name:	
	Address:	
	City:	State:
	Zip:	
	Telephone:	Cell#:
	Chief Complaint, Diagnoses and Body Parts:	

Treating Provider Information:	Provider Name:	
	Tax ID:	NPI:
	Telephone:	Fax:
	Address:	
	City:	State:
	Zip Code:	Specialty:

Referred Out of Network Provider Information:	Provider Name:	
	Tax ID:	NPI:
	Telephone:	Fax:
	Address:	
	City:	State:
	Zip Code:	Specialty:

Out of Network Referral Reasoning:	

Out of Network Provider Request Form

Requested Referred Services:	

Start Date of Requested Services:	**End Date of Requested Services:**

Required Information: Please attach all medical documentation including Statement of Medical Necessity, medical notes and any additional information needed to provide our Texas HCN of the necessity of the services requested.

Contact **Prime Health Services, Inc.** for further assistance at **1 (866) 348-3887**
Please email **completed** forms to Prime Health Provider Relations Department at
provider.relations@primehealthservices.com