California Policy for Reporting Work Related Injuries

When an injury occurs, please notify DecisionHR immediately at (888) 828-5511, Ext. 4101, 4272 or 4042. Then complete the following DecisionHR TeleClaim Workers' Compensation Form and Email to CLAIMREPORTING@DecisionHR.com or fax it to (855) 204-4169. Complete the DWC-1 (Workers' Compensation Claim Form) within one day of your knowledge of the injury/illness and provide the injured employee with a California Primary Medical Provider Network booklet. Fax the completed DWC-1 to DecisionHR, keep the employer's copy and give the injured employee a copy. All Employers are required to notify CAL/OSHA within 8 hours to report an employee fatality on the job or suffers a work-related hospitalization, amputation, or loss of an eye.

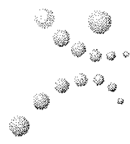
- **If an injury is life threatening:**
  1st – Dial 911 or seek the nearest hospital
  2nd – Notify DecisionHR immediately at the numbers listed above (*)

- **Information needed when reporting an injury:**
  1. Employee name and date of injury
  2. How injury occurred and specific body part injured
  3. Please fax the DecisionHR TeleClaim Workers' Compensation Form to DecisionHR immediately

- **If treatment is needed:**
  1. Direct the injured worker to one of the approved treatment facilities found in the DecisionHR Client Packet or at talispoint.com/aig/obn. For assistance in locating a facility, please contact DecisionHR at the phone numbers listed above.
  2. DecisionHR's claims personnel will work with you to determine whether a post-accident drug screen is necessary. Post-accident drug screens will only be administered when it was influenced or caused by a drug related activity. LabCorp offices in your area can be found at www.labcorp.com.
  3. Complete the temporary prescription card and give it to the injured worker to provide to the pharmacy.
  4.

***(*) After Hours:** If an injury occurs after hours, leave a message for DecisionHR and include the injury details, your company name, contact person and phone number. Then proceed with necessary medical care and fax the DecisionHR TeleClaim Workers' Compensation Form as explained above. If you need assistance after hours, please call (727) 512-0139.*

Important: All injuries are to be reported to Decision HR within 24 hours of occurrence. Failure to report timely may jeopardize employee benefits and subject employer to penalties by the Division of Workers' Compensation.



DecisionHR TeleClaim Workers' Compensation Form

WITHIN 24 HOURS OF NOTICE FROM INJURED EMPLOYEE:
COMPLETE THIS FORM IN ITS ENTIRETY and CONTACT DECISIONHR AT

Email: CLAIMREPORTING@DecisionHR.com Phone: (888) 828-5511 ext. 4101, 4042 or 4272

Client Company Name: ______________________________ Client #: ____________

Date of Loss: ____________ State in which loss occurred: ____________ State EE was Hired: ____________

Employee Information:

1. Employee's Full Name: ______________________________
2. Employee's Phone Number: ______________________________
3. Employee's Email Address: ______________________________
4. Employee's Social Security Number: ______________________________
5. Primary Language Spoken: ______________________________

Accident/Incident Information:

1. Date and time of accident: ______________________________
2. Date and time reported to employer: ______________________________
3. Who was the accident reported to: ______________________________
4. Employee Supervisor: ______________________________
5. Shift begin and end time: ______________________________
6. Address where accident/incident occurred (street, city, state, zip code and county): ______________________________
7. Is the above address the employer's premises? ___Yes ___ No
8. Full description of accident/incident (include what employee was doing, work process, cause, injury and body part): ______________________________
9. Is the accident/incident questionable to the employer? ___Yes ___ No
   If so, why?______________________________
10. Does the employer suspect drug and/or alcohol use at time of accident/incident? ___Yes ___ No
11. Date of death (if accident resulted in a fatality): ______________________________
12. Last date worked and time employee left work: ______________________________
13. First date missed: ______________________________
14. Was the employee paid in full on the date of injury? ___Yes ___ No
15. Has employee returned to work? ___Yes ___ No If yes, what date: ____________
    If no, is there an expected return to work date? ____________
16. Does employee have a previous claim? ___Yes ___ No

Accident/Incident Information:

1. Was any safety equipment provided? ___Yes ___ No If yes, was it used? ___Yes ___ No
2. Was an unsafe act being performed? ___Yes ___ No
   If yes, describe: ______________________________
3. Was a machine part involved? ___Yes ___ No
   If yes, describe part: ______________________________
4. Was the machine part defective? ___Yes ___ No
   If yes, in what way? ______________________________
5. Was a third party responsible for the accident/incident: ___Yes ___ No
   If yes, please list third party name, address and phone: ______________________________
   ____
6. Was the accident/incident witnessed? ___Yes ___ No
   If yes, please list witness name, address and phone: ______________________________
   ____
7. Name, address and phone of person to contact regarding additional loss information: ______________
   ____

Provider Information:

1. Was first aid given onsite? ___Yes ___ No If yes, what medical treatment was received? ___________
   ____
2. Clinic/Doctor – Doctor name, specialty (i.e.: family prac, chiro, etc.) address, city, St, zip & phone: _______
   ____
3. Hospital name, address, city, St, zip & phone: ______________________________
   ____
   ____
4. Was employee hospitalized? ___Yes ___ No If yes, on what date? ______________________________
5. Was employee:___treated-outpatient ____ received for emergency treatment ___ transported by ambulance
6. Name of person reporting this claim, including title and phone number: ______________________________
   ____

PLEASE have the Employee sign and date below as an acknowledgement that at this time the Employee has chosen to decline medical treatment:

____

Employee Signature

____

Date