WORKER'S COMPENSATION CLAIMS REPORTING

Serviced by: Georgia Administrative Services, Inc.
1775 Spectrum Drive, Suite 100
Lawrenceville, GA 30043
Phone (770) 963-7732 or (800) 421-0710
Fax (770) 963-5754

REPORTING A CLAIM

- **Complete form WC-1 – Employer's First Report of Injury or Occupational Disease and fax to (770) 963-5754 or email to firstreport@gaadminsvcs.com.** This should be done immediately upon knowledge of the injury. ALL claims should be reported, no matter how minor. If the claimant does not receive treatment, please mark the top of the First Report of Injury form "FOR REPORTING PURPOSES ONLY". The claim will be processed for record only. *Please use the form WC-1 updated 07/2017 at the bottom.*

- **Complete form WC-6 – Wage Statement** and fax to (770) 963-5754 or email to firstreport@gaadminsvcs.com. We must have 13 weeks gross income PRIOR to the date of accident.

- **Complete the Supervisor's Report** and fax to (770) 963-5754 or email to firstreport@gaadminsvcs.com. Please include as much detail as possible.

- **Forward any medical records, bills or personal information that may affect the injury.**

- **Contact the adjuster immediately if you question the claim.** We have 21 days from the date you are aware of the injury to accept or deny the claim.

MEDICAL CARE

- **Offer the Panel of Physicians (pink form WC-P1) to the injured worker and have her/him select a physician for treatment.** If the nature of the injury is serious and requires immediate care, the employee may seek treatment at the emergency room or walk-in clinic as long as they follow up with a panel physician.

- **If the employee is not satisfied with their treating physician they must contact the adjuster in order to change physicians.**

- **Medication can be filled at any pharmacy as long as the adjuster is called for authorization.**

- **The adjuster must approve all medical treatment such as tests, physical therapy, medications, referrals, etc.**

PANEL

You are responsible for contacting the posted physicians on a quarterly basis to ensure the panel remains valid. Please verify the providers continue to accept workers' compensation patients, are in the same practice and the correct addresses and phone numbers are posted on the panel.

If you would like to replace or add a physician to your panel please fax a copy of the currently posted panel to Karen Sprouse at (770) 963-5754 with your request.

When you replace your panel, always keep the old panel in a file with the date you took it down for reference on prior claims.

WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	❑ Male ❑ Female	Birthdate	Phone Number	Employee E-mail
Address		City	State	Zip Code

EMPLOYER	Name	NAICS Code	Nature of Business (Trade, Transport, Mfg.,etc.)
Address		Phone Number	Employer FEIN
City	State / Zip Code	Employer E-mail	

INSURER / SELF-INSURER	Name	Insurer/Self-Insurer FEIN	Insurer/ Self-Insurer File #
CLAIMS OFFICE	Name	Claims Office FEIN # / Claims Office Phone	Claims Office E-mail
SBWC ID# (five digit no.)	Address	City / State / Zip Code	

EMPLOYMENT/WAGE	Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease: ❑ per Hour ❑ per Day ❑ per Week ❑ per Month
Insurer Type Code ❑I – Insurer ❑S-Self-insurer ❑Group Fund	List Normally Scheduled Days Off			

INJURY/ILLNESS & MEDICAL	Time of Injury ❑ am ❑ pm	County of Injury	Date Employer had knowledge of Injury	Enter First Date Employee Failed to Work a Full Day
Did Employee Receive Full Pay on Date of Injury? ❑ Yes ❑ No	Did Injury/Illness Occur on Employer's premises? ❑ Yes ❑ No	Type of Injury/Illness	Body Part Affected	
How Injury or Illness / Abnormal Health Condition Occurred				

Treating Physician (Name and Address)	Initial Treatment Given: ❑ None ❑ Minor: By Employer ❑ Minor: Clinical/Hospital ❑ Emergency Room ❑ Hospitalized > 24hrs	Hospital / Treating Facility (Name and Address)	If Returned to Work, Give Date: Returned at what wage per Week If Fatal, Enter Complete Date of Death

Report Prepared By (Print or Type)	Telephone Number	Date of Report

❑ B. INCOME BENEFITS **Form WC-6 must be filed if weekly benefit is less than maximum**

Previously Medical Only ❑ Yes ❑ No

Average Weekly Wage: $ _____ Weekly benefit: $ _____ Date of disability:

Date of first Payment: _____ Compensation paid: $ _____ or Date salary paid: _____ Penalty paid: $ _____

BENEFITS ARE PAYABLE FROM _____ FOR:

❑ Temporary total disability ❑ Temporary partial disability ❑ Permanent partial disability of _____ % to _____ for _____ weeks.

UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.

❑ C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

❑ D. MEDICAL ONLY INJURY **(No indemnity benefits are due and/or have NOT been controverted.)**

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	Date
Phone Number	E-mail	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.

2. Complete Section A of this form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY**.
   Do not send this form to the State Board of Workers' Compensation.

3. If you need additional help, call your insurance company or self-insurer claims office.

4. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

NOTICE TO INSURER / SELF-INSURER

1. Complete Section B, C, or D.
   This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form must be sent to the claimant(s) and all counsel of record. Section B: completed when indemnity benefits are paid. Section C: completed when claim is controverted. Section D: completed when no indemnity benefits are due and/or have NOT been controverted. Form W-6 must be filed if weekly benefits are less than the maximum.

NOTICE TO EMPLOYEE

1. This form is provided for your information only.

   If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

   If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a form WC-14, Notice of Claim, within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

   If Section D is completed, you will receive medical benefits only. At this time, indemnity benefits are not due. If your medical bills are not paid, call your employer or your employer's insurance company or self-insured claims office.

For Information or Assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free Telephone: 1-800-533-0682
In Atlanta: (404) 656-3818

http://www.sbwc.georgia.gov

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

Instructions: This form shall not be filed with the Board, unless otherwise requested

TO:		
Print Name and Title		
Address		
City	State	Zip Code

RE: Employee / Patient		
Last Name	First Name	M.I.
SSN or Board Tracking #	Date of Injury	Birthdate

This document authorizes the release of only the medical information as provided below. The above-stated entity, facility or medical practitioner is authorized to release medical information to _____ in accordance with applicable State and Federal laws.

The information covered by this Authorization and Consent to Release is that authorized by O.C.G.A. !34-9-207 which reads as follows:

(a) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury arising from the incident that the employee has had with any physician, including, but not limited to, communications with psychiatrists or psychologist. This waiver shall apply to the employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Notwithstanding any other provision of law to the contrary, when requested by the employer, any physician who has examined, treated, or tested the employee or consulted about the employee shall provide within a reasonable time and for a reasonable charge all information and records related to an examination, treatment, testing, or consultation concerning the employee.

(b) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, the employee, upon request, shall provide the employer with a signed release for medical records and information related to the claim or history or treatment of injury arising from the incident, including information related to the treatment for any mental condition or drug or alcohol abuse and to such employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Said release shall designate the provider to whom the release is directed. If a hearing is pending, any release shall expire on the date of the hearing.

(c) If the employee refuses to provide a signed release for medical information as required by this Code section and, in the opinion of the Board, the refusal was not justified under the terms of this Code section, then such employee shall not be entitled to any compensation at any time during the continuance of such refusal or to a hearing on the issues of compensability arising from the claim.

Federal regulations (42 CFR Part 2), and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 45 CFR 164.512(1) which reads as follows: "The covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related illnesses or injury without regard to fault." Anyone who receives information under this authorization receives the same under all limitations set forth in Federal and State law regarding further dissemination of such information.

This release shall expire in 180 days or upon written notice of revocation by the patient. If a hearing is pending, this release shall remain in effect until the hearing and shall expire on the date the hearing is held.

Employee / Patient Signature	**Date**

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO EMPLOYEE OF OFFER OF SUITABLE EMPLOYMENT

Instructions: The employer shall use this form to notify an employee of an offer of employment which is suitable to his/her impaired condition, as required by O.C.G.A. ! 34-9-240 and Board Rule 240. This form, with all attachments, must be provided to the employee and counsel for the employee at least ten days prior to the date the employee is expected to return to work. This form, along with attachments, should only be filed with the Board as an attachment to a Form WC-2.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Address		
Employee E-mail		City	State	Zip Code
EMPLOYER	Name	Address		
Employer E-mail		City	State	Zip Code

B. NOTICE TO EMPLOYEE

1. This is to inform you that the following job is being made available to you pursuant to the requirements of O.C.G.A. ! 34-9-240 and Board Rule 240 (b):

Title	
Essential Duties (Attach Additional Pages as needed)	
Rate of Pay	Location of Job
Hours / Days to be Worked	Date / Time to Report for Work

2. A copy of the report(s) of your authorized treating physician(s), approving the job as suitable to your condition, is / are attached.

3. If you unjustifiably refuse to attempt to perform the job offered after receiving this notification or if you attempt the job for less than eight cumulative hours or one scheduled work day, whichever is greater, the employer/insurer shall be authorized to suspend payment of income benefits to you effective the date you are scheduled to report to work. Should you attempt but fail to continue working for fifteen (15) scheduled work days, your income benefits shall immediately be reinstated.

4. If you have any questions about the job being offered to you, you may contact the employer at: _____ .

C. CERTIFICATION

0 I hereby certify that the above-named job is available to this employee as outlined above, that the job duties have been approved by the authorized treating physician(s) who has examined the employee within 60 days of the attached approval, and that this offer is being made in good faith no later than ten days prior to the date the employee is expected to report for work. I further certify that I have this day sent a copy of this form to the employee and counsel for employer (if represented.)

Print Name / Title Here	E-mail	Address		
Signature	Date	City	State	Zip Code

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

WAGE STATEMENT

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Address		
E-mail Address		City	State	Zip Code
EMPLOYER	Name	Address		
E-mail Address		City	State	Zip Code
INSURER/ SELF-INSURER	Name	SBWC ID# (five digit number)		
CLAIMS OFFICE	Name	Claims Office Address		
E-mail Address	Insurer/Self-Insurer File #	City	State	Zip Code

B. COMPUTATION OF AVERAGE WEEKLY WAGE

If the weekly benefit is less than the maximum, complete the schedule below for thirteen (13) weeks immediately preceding the accident. If the employee has not been in your employ for the thirteen (13) weeks, complete this schedule showing gross weekly earnings of a similar employee in the same employment. If either of the foregoing methods cannot be reasonably and fairly applied, the full time weekly wage of the injured employee should be used.

❑ 13 Weeks of Employee's Wages ❑ 13 Weeks of a Similar Employee's Wages ❑ Full Time Weekly Wage of Injured Employee: $_____

SCHEDULE OF WEEKLY EARNINGS

Week	From Date MM/DD/YYYY	To Date MM/DD/YYYY	No. of Days Worked	Gross Amount Paid Including Overtime or Extra Work	Value of Additional Compensation					Total Earnings
					Meals	Lodging	Rent	Tips	Other	
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
			Total							
			Average Weekly Earnings							

C. SCHEDULED DAYS OFF

REQUIRED TO COMPLETE: ❑ Mon ❑ Tue ❑ Wed ❑ Thur ❑ Fri ❑ Sat ❑ Sun ❑ No Off Days

D. REMARKS

REMARKS:

Type or Print Name	Signature	Date
E-mail Address	Phone Number	

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POST-OFFER-OF-EMPLOYMENT MEDICAL INQUIRY

Completion of this report is requested to assist your employer with the claims management process.

Name_____ Department_____ Position_____

To the best of your knowledge do you have or have had any of the following medical problems?

Answer YES or NO

_____ 1. **Epilepsy**
_____ 2. **Diabetes**
_____ 3. **Arthritis**
_____ 4. **Amputated foot, leg, arm or hand**
_____ 5. **Loss of sight** of one or both eyes or a partial loss of uncorrected vision of more than 75% bilaterally
_____ 6. **Residual disability from Poliomyelitis**
_____ 7. **Cerebral palsy**
_____ 8. **Multiple sclerosis**
_____ 9. **Parkinson's disease**
_____10. **Cardiovascular disorders**
_____11. **Tuberculosis**
_____12. **Mental retardation**, provided the employee's intelligence quotient is such that he falls within the lowest 2% of the general population; provided, however, that it shall not be necessary for the employer to know the employee's actual intelligence quotient of the general population
_____13. **Psychoneurotic disability** following confinement for treatment in a recognized medical or mental institution for a period in excess of six months
_____14. **Hemophilia**
_____15. **Sickle cell anemia**
_____16. **Chronic osteomyelitis**
_____17. **Ankylosis** of major weight bearing joints
_____18. **Hyperinsulism**
_____19. **Muscular dystrophy**
_____20. **Total occupational loss of hearing** as defined in Code 34-9-264
_____21. **Compressed air sequelas**
_____22. **Ruptured intervertebral disc**
_____23. **Back conditions** (Identify below)
__ a. back surgery
__ b. degenerative disc disease
__ c. multiple back strains
__ d. chronic back pain
__ e. other (explain)
_____24. **Neck conditions** (Identify below)
__ a. neck surgery
__ b. degenerative disc disease
__ c. multiple neck strains
__ d. chronic neck pain
__ e. other (explain)
_____25. **Knee conditions** (Identify below)
__ a. left knee surgery
__ b. right knee surgery
__ c. other (explain)
_____26. **Hip replacement surgery**
_____27. **Any permanent condition that has been rated by a doctor as 20%, or more, impairment to the foot, leg, hand, arm, or to the body as a whole**
_____28. **Any other chronic medical condition or pre-existing disease (explain below)**

For "yes" responses indicate the nature of injury or illness and name of physician in Remarks.

Remarks_____

_____

Employee Signature_____ Date_____

Employer Signature_____ Date_____

OFERTA DE EMPLEO EN INVESTIGACION MÉDICA

La terminación de este reporte es solicitada para ayudar su empleador con el porceso de el reclamo.

Nombre_____Departamento_____Posicion_____

¿Hasta donde usted sabe ha tenido o tiene alguno de los problemas médicos siguientes?
Conteste si o no

_____ 1. **Epilepsia**
_____ 2. **Diabetes**
_____ 3. **Artritis**
_____ 4. **Amputación de pie, pierna, mano o brazo**
_____ 5. **Perdida de vista** de un ojo o de ambos o perdida de vista parcial parcial o vista que no pueda ser corregida mas 75% bilateral
_____ 6. **Discapacidad Residual por Poliomielitis**
_____ 7. **Parálisis Cerebrar**
_____ 8. **Esclerosis Múltiple**
_____ 9. **Enfermedad de Parkinson**
_____10. **Padecimiento Cardiovascular**
_____11. **Tuberculosis**
_____12. **Retraso Mental,** siempre y cuando el coeficiente intelectual sea tal que el resultado del empleado caiga dentro del 2% del de la población general, siempre y cuando, sin embargo, no sea necesario que el patrón sepa el coeficiente verdadero del empleado con respecto al de la población general
_____13. **Incapacidad Psiconeurotica** después de haber estado bajo tratamiento en una institución medica o mental reconocida por mas de seis meses
_____14**. Hemofilia**
_____15**. Anemia Drepanóctica**
_____16. **Osteomielitis Crónica**
_____17. **Anquilosis en las coyunturas que soportan mas peso**
_____18. **Hiperinsulinismo**
_____19. **Distrofia Muscular**
_____20. **Perdida total de la audición laboral** como definido en el Código 34-9-264
_____21. **Secuela por causa de Aire Comprimido**
_____22. **Disco Intervertebral roto**
_____23. **Padecimientos de Espalda** (identifique)
__ a. cirugía de la espalda
__ b. padecimiento de disco decaído
__ c. relajamientos múltiples de espalda
__ d. dolor de espalda crónico
__ e. otro (explique)
_____24. **Padecimiento del Cuello** (Identifique)
__ a. cirugía del cuello
__ b. padecimiento de cuello decaído
__ c. relajamientos múltiples del cuello
__ d. dolor de cuello crónico
__ e. otro (explique)
_____25. **Padecimiento de Rodillas** (Identifique)
__ a. cirugía en la rodilla izquierda
__ b. cirugía en la rodilla derecha
__ c. otro (explique)
_____26. **Cirugía de reemplazo de cadera**
_____27. **Cualquier padecimiento permanente que su doctor determine como un impedimento de un 20% al pie, pierna, mano o brazo o el cuerpo entero**
_____28. **Cualquier otro padecimiento medico crónico o enfermedad (explique)**

Para las respuestas de 'Si" indique el origen del padecimiento o lesión y el nombre del medico en Observaciones.

Observaciones: _____

_____

Firma del Empleado_____ Fecha_____

Firma del Patrón_____ Fecha_____

STATEMENT OF THE INJURED

NAME: _____ MARRIED/SINGLE_____

ADDRESS_____TELEPHONE_____

SOCIAL_____DATE OF BIRTH_____M/FM_____

HEIGHT/WEIGHT_____RIGHT/LEFT HANDED_____

DEPENDENTS (NAME/AGE)_____

EMPLOYER_____OCCUPATION_____

DATE OF HIRE_____

DATE OF ACCIDENT_____PLACE OF ACCIDENT_____

TIME OF ACCIDENT:_____am/pm

DESCRIBE THE ACCIDENT IN DETAIL, WHAT YOU WERE DOING, WHAT HAPPENED:

DESCRIBE YOUR INJURY:_____

NAME/ADDRESSES OF WITNESSES/PERSONS HAVING KNOWLEDGE: _____

NAME OF PHYSICIAN ARE/HAVE SEEN:_____

HIS ADDRESS/PHONE:_____

DATE OF FIRST VISIT:_____

FOLLOW UP TREATMENT_____

DIAGNOSIS_____

EXCUSED FROM WORK/ HOW MANY DAYS_____

MODIFIED WORK GIVEN/ WHAT RESTRICTIONS_____

HISTORY:

ANY PREVIOUS ACCIDENTS OR INJURIES (work or otherwise) PLEASE GIVE DETAILS_____

DO YOU HAVE ANY SERIOUS ILLNESSES, PLEASE EXPLAIN_____
_____

PERSONAL PHYSICIAN'S NAME, ADDRESS, PHONE:_____

_____

_____ _____
INJURED EMPLOYEE DATE

SUPERVISOR'S REPORT

EMPLOYER:_____

NAME OF INJURED:_____

DATE OF INJURY:_____

Supervisor/Title (Completing this form):_____

Home Address:_____ Phone: ( )_____
(Street) (City, State, Zip code)

Your Current Job Title:_____ Length of time in position:_____

Length of time with current employer:_____

Positions held (if different than above)_____

INJURY INFORMATION:

Nature of Injury, Part of Body affected:_____

Describe the Accident and how it occurred:_____
_____

Cause of the Accident:_____

Witness(es):_____ Statement taken? (Y/N)_____
_____ _____
_____ _____

Any reason to question the accident, if so why?_____

Safety training provided to the injured? Yes_____ No_____

Corrective actions taken to prevent recurrence:_____

What Physician did the Injured choose from the Panel_____

Did the physician excuse the injured from work if so how long? _____
Did the Physician give work restrictions? If so, what are they_____
Was Modified work recommended? If so was work provided?_____

Please check the list below if completed:
_____ First Report _____Statement of the Injured
_____ Witness Statement _____ Designated Physician Form
_____ Physician Appt for Injured _____ Job Analysis(if restrictions are given)

_____ _____
Supervisor Signature Date