Workers' Compensation Claims Reporting Procedures

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

Any workers' compensation injury should be reported by the manager immediately, and in all cases within 24 hours of the occurrence of the accident. Report all workers' compensation injuries by phone to the following number and you will be provided with an incident number:

Phone: 1-855-902-5818

The Archdiocese has a preferred provider relationship setup with Ochsner Occupational Health. They have the Archdiocese WC billing instructions setup in their system and know that they must send the employee with a work status report to provide to the claim adjuster. Please complete and sign the ANO WC Ochsner Medical Authorization Form on page 4 and include the incident number received from the call center and send this with the employee. This form can still be used if the employee goes to see a different provider as the billing information is the same.

You can also report the claim via Email by completing the Accident/Injury Report Form (included in this packet).
Email to: riskmanagement@arch-no.org

Questions/Support

If you have any questions about claims reporting, please contact your Manager or the CCMSI Claims Team Manager, Bob Richards.

Claims Team email: rrichards@cmsi.com
Claims Team phone: 504-883-8415

Send the injured employee to an occupational medicine facility near your facility.

- If you currently have a WC clinic where you send your injured employees, you can continue to utilize this facility.
- If you prefer to locate a provider/clinic on your own or have additional questions about providers, you can contact the CCMSI claims supervisor for assistance.
- If possible, send a representative (one who can discuss the employee's duties) with the injured worker to the medical facility.
- Complete the following forms and send them with the injured employee to the treatment facility.
  - Treatment Guideline
  - Pharmacy First Fill Form (included in this packet)
- Remind your injured employee that a post-accident drug test will be performed at the treatment facility.

Treatment Guide
The Treatment Guide is included in this claim packet. This form must be completed and taken to the treatment facility by the injured employee in order to ensure the timely payment of claims related medical bills. Please provide all requested information on the form.

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

If you do not have all of the information requested on the Accident/Injury Report, do not delay reporting the claim. Missing information can be given to the adjuster after the claim has been reported.

ARCHDIOCESE OF NEW ORLEANS

Accident/Injury Report

Complete all sections of this form and report the accident/injury immediately via email or phone. You can email a copy of this form to: riskmanagement@arch-no.org or call 1-855-902-5818 to speak to a representative.

I. Archdiocese of New Orleans

Location Name			
Street Address	**City**		**State** **Zip**
Phone Number -	**Email**	**Contact**	

II. Injured Employee Information

Employee Name		**Phone Number** -	
Street Address	**City**	**State**	**Zip**
Social Security Number	**Job Title**	**WC Class Code**	
Date of Hire	**Date of Birth**	**Rate of Pay** $ per	

III. Accident Information

Date of Accident **Time of A**	**cident** ☐AM ☐PM	**Date and Time accident was first reported to Management** **Date:** **Time:** ☐AM ☐PM	
Address Where Accident Occurred	**City**	**State**	**Zip**
Has Employee Returned to Work ☐Yes ☐No	**If yes, indicate date the employee returned to work**		

Provide a detailed description of the accident <u>Including the extent of injuries and body part affected.</u>

Did employee seek medical treatment? ☐Yes ☐No	**If yes, where?**
Were there any witnesses? ☐Yes ☐No	**If yes, please furnish names, addresses and phone numbers.**

Please Note: Post-Accident Drug Screening Will Be Performed

Employee Signature	**Employer Signature**

IV. Treatment Refusal

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

Employee Signature	**Employer Signature**

ARCHDIOCESE OF NEW ORLEANS

Treatment Guide

Employee Name		**Date of Accident** / /
Social Security Number - -		
Nature of Injury and Body Part		
Company Name		
Contact	**Title**	**Date** / /

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

Please complete a post-accident 5-Panel drug test utilizing your chain of custody form.

We often have modified work available that would allow the employee to return to work at the earliest possible date. Please keep this in mind as you treat our employee.

Our workers' compensation insurance is provided through Safety National and administered by CCMSI.

Please note that this letter does not confirm that the injury or condition is covered by Workers' Compensation insurance. That determination will be made when a CCMSI claims representative completes a review/investigation.

Please submit all medical records, bills (including post-accident drug test charges) and documentation within the time frame required by applicable state law. Send directly to our Claims Administrator at the following address.

CCMSI
Bill Processing Unit
2 East Main Street
Towne Centre Bldg. Suite 208
Danville, IL 61832-5852

An assigned adjuster will inform the provider of any address changes for bill submission after the initial treatment.

Employer Authorization for Examination and/or Treatment Employee On the Job Injury

EMPLOYEE / EMPLOYER

Employee Name: _____ Today's Date: _____

Date of Birth: _____ Date & Time of Injury: _____

Employer Name: _____ Phone: _____

Address: _____ Facsimile: _____

Person Authorizing Visit: _____ Title: _____

Signature of Person Authorizing:

_____ Date: _____

Email: _____ Direct Phone #: _____

CCMSI Incident or Claim Number: _____

REQUESTED SERVICES

Initial evaluation and treatment, approved. If further treatment is needed contact CCMSI via 1010 request. All 1010's must be faxed to 504-888-0863.

Comments: _____

_____

WORKERS' COMPENSATION BILLING / INSURED INFORMATION

Billing Address: CCMSI, P.O Box 7457, Metairie, LA 70010

Billing Contact: Ashley Johnson **Phone: 504-883-8496** **Email: ashley.johnson@ccmsi.com**

Sonia Robinson Phone: 504-883-8433 Email: srobinson@ccmsi.com

Insured Name: The Roman Catholic Church of the Archdiocese of New Orleans

Insured Address: 7887 Walmsley Ave, New Orleans, LA 7125

Insured Contact: Riskmanagent@arch-no.org

Drug test only Results to be emailed to Archdiocese at: clandry@arch-no.org

Do not email drug tests results to Risk management email address

CCMSI Adjusters: Ashley Johnson Phone: 504-883-8496 Email: ashley.johnson@ccmsi.com

Sonia Robinson Phone: 504-883-8433 Email: srobinson@ccmsi.com