



ASSOCIATED
CLAIMS
ADMINISTRATORS

Dear Employer:

Associated Claims Administrators (ACA) will be administering your Workers' Compensation claims on behalf of National Liability & Fire Insurance Company.

ACA professionals are experienced in Workers' Compensation Law. Please feel free to call our office with any questions you may have regarding your Workers' Compensation concerns.

Early involvement in a claim is important. It is not only cost effective for you, but it also can help the injured employee get proper medical care and return to work as soon as possible. We look forward to working with you to accomplish these goals.

You, the employer, are a vital part of making this happen and listed below are some things you can do:

Review the attached list of Frequently Asked Questions.

1. Report all work related injuries to ACA as soon as you are aware of them. Our toll-free fax number is **1-800-988-4722**.
2. You may report all work-related injuries to ACA by email at claims@acaworkcomp.com, or call **1-800-388-6268** for assistance reporting a claim.
3. Refer all medical authorization requests to ACA.
4. Communicate with your employee and ACA throughout the claim.
5. Have some light duty work available for restricted duty.
6. Advise ACA when the employee returns to work.

Please keep copies of the attached forms to have on hand if needed.

We look forward to a long and pleasant working relationship with you and your employees.

Please call anytime between 8:00am and 5:00pm Central Time, Monday through Friday if you have any questions regarding Worker's Compensation claims procedures.

Best Regards,

Associated Claims Administrators

Frequently Asked Questions re: Claims

What is the “waiting period”?

Each state regulates the number of days an injured worker must be off work due to a work related injury before compensation (wage) payments may begin. This period is referred to as a “waiting period” and the number of days varies by state law. The State of Tennessee defines the waiting period as 7 days. Compensation payments begin on the 8th day.

Will an injured worker be paid for the days within the waiting period?

An injured worker may receive compensation payments for the number of days off comprising the waiting period, if he or she is out of work due to the injury longer than a specified period of time.

The reimbursement of waiting period for the State of Tennessee is defined as 14 days following the date of disability according to state law. If an injured worker’s disability lasts longer than 21 days, he/she will be reimbursed for the 7 day waiting period.

How do we obtain a list of medical providers or the Employers’ Posted Panel?

Rules and regulations regarding approved medical providers and/or Employers’ Posted Panels for treatment of injured workers vary by state. It is important for every employer to understand how to identify and utilize medical providers and/or Employers’ Posted Panels. For assistance obtaining a list of preferred providers and/or help setting up an Employers’ Posted Panel, please contact the claims office at (800) 388-6268.

Do we have to provide light duty?

Providing light duty within the guidelines of a medically restricted employee of a compensable claim often shortens the length and reduces the total cost of the claim. While light duty may not be possible for some employers, it is recommended that all employers work to incorporate a light duty/return to work program.

How is the compensation rate calculated?

The compensation rate is 2/3 of the average weekly gross earnings of the injured worker. The number of weeks used for calculating varies by state and is subject to the state’s minimum/maximum at the time of accident.

The State of Tennessee uses gross wages for 52 weeks preceding the date of accident to determine the average weekly gross earnings.

How does the claimant obtain their medication?

The injured worker can obtain their medication from any pharmacy. They should provide the pharmacy with the contact information for ACA for further billing instructions and/or approval as provided below:

Associated Claims Administrators, Inc.
P.O. Box 230848
Montgomery AL 36123-0848

Toll Free: (800) 388-6268
Fax (Toll Free): (800) 988-4722
Email: claims@acaworkcomp.com

Can an employer be reimbursed for medical billing they pay?

If the authorized medical billing relates to the compensable claim, the billing will be reviewed for possible reimbursement at the state fee schedule rate.

If we have a deductible can we pay the claims up to the deductible amount?

No. A deductible applies per claim and is set up on a reimbursement basis. That means you, the employer, should file a First Report of Injury on all work related accidents. If our investigation leads to payment of the claim, we will cover costs first dollar and submit one or more invoices to you for reimbursement as payments are made up to the total/maximum per claim deductible amount noted on your policy.

Not all policies have a deductible. Your policy will include a deductible amount on the Workers’ Compensation Policy Information Page if your policy has a deductible.



**TENNESSEE BUREAU OF WORKERS' COMPENSATION
EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS**

CLAIMS ADM/CARRIER	JURISDICTION CLAIM # (STATE FILE #)		CLAIM TYPE CODE <input type="checkbox"/> MED ONLY <input type="checkbox"/> INDEMNITY <input type="checkbox"/> BECAME LOST TIME <input type="checkbox"/> BECAME MED ONLY <input type="checkbox"/> NOTIFY ONLY <input type="checkbox"/> TRANSFER		<p>THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE TENNESSEE WORKERS' COMPENSATION LAW AND MUST BE COMPLETED AND FILED WITH YOUR INSURANCE CARRIER IMMEDIATELY AFTER NOTICE OF INJURY.</p> <p>IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS' COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.</p> <p>IF YOU HAVE QUESTIONS, THE STATE NOW HAS A BENEFIT REVIEW SYSTEM WHERE A WORKERS' COMPENSATION SPECIALIST CAN PROVIDE ASSISTANCE. CALL 1-800-332-2667 (TDD).</p>				
	CLAIMS ADM CLAIM # (INSURER CLAIM #)		CARRIER FEIN						
	OSHA LOG CASE #		FEIN OF CLMS ADM						
	NAME OF INSURANCE CARRIER		CLMS ADJ PHONE #						
	CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)		CITY					STATE	ZIP
	CLAIMS ADJUSTER NAME		STATE					ZIP	
	CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2		CITY					STATE	ZIP
EMPLOYER	EMPLOYER NAME		EMPLOYER FEIN		SIC CODE	PHONE NUMBER			
	EMPLOYER ADDRESS LINE 1 AND LINE 2				NATURE OF BUSINESS				
	CITY		STATE	ZIP	INSURED REPORT #	EMPLOYER LOCATION			
POLICY	INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)		POLICY NUMBER		EFF DATE	EMPLOYMENT STATUS CODE <input type="checkbox"/> FULL TIME/REGULAR <input type="checkbox"/> PART TIME <input type="checkbox"/> PIECE WORKER <input type="checkbox"/> SEASONAL <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> APPRENTICE FULL TIME <input type="checkbox"/> APPRENTICE PART TIME			
			SELF INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO		EXP DATE				
EMPLOYEE	EMPLOYEE LAST NAME		PHONE INCL AREA CODE		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN				
	FIRST	MI	DEPARTMENT REGULARLY WORKED		OCCUPATION DESCRIPTION				
	ADDRESS LINE 1 & 2		CITY		STATE	ZIP			
	SSN		DATE OF BIRTH	DATE OF HIRE		MARITAL STATUS <input type="checkbox"/> UNMARRIED, SINGLE, DIVORCED	<input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN		
	CITY		STATE	ZIP	NCCI CLASS CODE				
WAGE	WAGE \$	PERIOD <input type="checkbox"/> WEEKLY <input type="checkbox"/> HOURLY <input type="checkbox"/> DAILY	NUMBER OF DAYS WORKED PER WEEK		SALARY CONTINUED IN LIEU OF COMPENSATION <input type="checkbox"/> YES <input type="checkbox"/> NO				
					FULL WAGES PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO				
ACCIDENT/INJURY	DATE OF INJURY		TIME OF INJURY <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> COULD NOT BE DETERMINED		TIME EMPLOYEE BEGAN WORK ON INJURY DATE <input type="checkbox"/> AM <input type="checkbox"/> PM				
	DATE EMPLOYER NOTIFIED OF INJURY		BODY PART AFFECTED CODE		NATURE OF INJURY CODE	CAUSE OF INJURY CODE			
	DATE CLAIM ADM NOTIFIED OF INJURY		HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE INCIDENT INCLUDING WHAT THE EMPLOYEE WAS DOING JUST BEFORE, THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY HARMED THE EMPLOYEE.						
	DATE LAST DAY WORKED								
	DATE DISABILITY BEGAN								
	RETURN TO WORK DATE (IF APPLICABLE)								
	DATE OF DEATH (IF APPLICABLE)		IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP						
	DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> WIDOW	<input type="checkbox"/> FATHER	___ SISTER	TOTAL # DEPENDENTS			
		<input type="checkbox"/> WIDOWER	___ DAUGHTER	___ BROTHER					
		<input type="checkbox"/> MOTHER	___ SON	___ HANDICAPPED CHILD					
ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)					COUNTY OF INJURY				
CITY					STATE	ZIP			
TREATMENT	PHYSICIAN NAME		HOSPITAL OR OFF SITE TREATMENT NAME						
	ADDRESS LINE 1 AND 2		ADDRESS LINE 1 AND 2						
	CITY	STATE	ZIP	CITY	STATE	ZIP			
	INITIAL TREATMENT <input type="checkbox"/> NO MEDICAL TREATMENT		<input type="checkbox"/> MINOR BY EMPLOYER <input type="checkbox"/> MINOR BY CLINIC/HOSPITAL	<input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> EMERGENCY CARE		<input type="checkbox"/> FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED			
OTHER	DATE PREPARED		PREPARER'S NAME & TITLE		PREPARER'S COMPANY NAME				
					PHONE NUMBER				



**Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002**

FORM C-41

WAGE STATEMENT

EMPLOYEE: _____ SSN: _____ STATE FILE #: _____

Employer _____ Ins Claim # _____ Date of Injury: _____

Please list the wages earned by the employee named above during each of the 52 weeks prior to date of injury, if applicable.

WEEK	WEEK ENDING	GROSS WAGES	WEEK	WEEK ENDING	GROSS WAGES
1			27		
2			28		
3			29		
4			30		
5			31		
6			32		
7			33		
8			34		
9			35		
10			36		
11			37		
12			38		
13			39		
14			40		
15			41		
16			42		
17			43		
18			44		
19			45		
20			46		
21			47		
22			48		
23			49		
24			50		
25			51		
26			52		
				TOTAL PAID	

Date: _____ Name of Preparer and Title _____

TENNESSEE WORKERS' COMPENSATION INSURANCE POSTING NOTICE

How to Report Work-Related Injuries

What should be done if injured at work?

Employee

1. Immediately **report the injury** to the employer representative named below.
2. **Select a treating physician** from a panel provided by your employer.
3. If you have questions or problems, contact the employer representative or the Bureau of Workers' Compensation.

Employer

1. Complete your company's internal "Workplace Injury form" and **notify your workers' compensation insurance company** immediately, even if you have concerns about the validity of the claim.
2. **Offer a panel of physicians** to the employee via Form C-42 available on the Bureau's website. *In cases of emergency, call an ambulance and provide this form as soon as the injured employee has stabilized.*

*Printed **name and title** of the employer representative to be notified in the event of a work-related injury*

*Printed name of an **alternative employer representative** to be notified in the event of a work-related injury*

***Telephone number** of employer representative to notify in event of a work-related injury*

***Address** of employer representative to notify in event of a work-related injury*

The Tennessee Bureau of Workers' Compensation is available to help both employees and employers.



220 French Landing Dr. 1-B
Nashville, TN 37243-2667
800-332-2667
615-532-4812 TTD: 800-332-2257
tn.gov/workerscomp

Workers' Compensation law requires this notice to be posted in a conspicuous place at the work site at all times.

SEGURO DE COMPENSACIÓN A TRABAJADORES DE TENNESSEE

PUBLICACIÓN DE AVISO

Cómo informar de lesiones laborales

¿Qué se debe hacer en caso de lesión laboral?

Empleado

1. **Informe** inmediatamente de **la lesión** al representante del empleador indicado aquí abajo.
2. **Seleccione un médico tratante** del panel provisto por su empleador.
3. Si tiene alguna pregunta o problema, comuníquese con el representante de empleadores de la Oficina de Compensación a Trabajadores.

Empleador

1. Complete el formulario interno de su empresa de "Lesión laboral" y **notifique a su aseguradora de compensación a trabajadores** inmediatamente, incluso aunque tenga dudas acerca de la validez de la reclamación.
2. **Ofrezca un panel de médicos** al empleado a través del Formulario C-42, disponible en el sitio web de la Agencia. *En casos de emergencia, llame a una ambulancia y proporcione este formulario en cuanto el empleado lesionado se haya estabilizado.*

Nombre en letra de molde y título del representante del empleador a ser notificado en caso de una lesión laboral

Nombre en letra de molde del representante del empleador alternativo a ser notificado en caso de una lesión laboral

Número de teléfono del representante del empleador a ser notificado en caso de una lesión laboral

Dirección del representante del empleador a ser notificado en caso de una lesión laboral

La Oficina de Compensación a Trabajadores de Tennessee está disponible para ayudar a empleados y empleadores.



220 French Landing Dr. 1-B
Nashville, TN 37243-2667
800-332-2667
615-532-4812 TTD: 800-332-2257
tn.gov/workerscomp

La ley de Compensación a Trabajadores exige que se publique este aviso en un lugar visible en el centro de trabajo en todo momento.



Employer

- List at least three physicians and provide this panel to employee upon the report of a workplace injury.
- Keep the completed original form on file and send a copy to the employee for their records.
 - Do *not* send this form to the State unless requested.

Employee

- Fill out the bottom portion of this form to indicate which physician you choose.
 - If you refuse to accept medical services from the chosen physician, your rights to benefits may be delayed.
 - Traveling more than 15 miles (one way) to (or from) medical treatment? Employees may seek reimbursement of their travel expenses from the insurance carrier.
- **Send** completed form **back to your employer**.

TO BE COMPLETED BY THE EMPLOYER:

Employee Name _____ Date Panel Provided _____

Employer _____ Date of Injury _____

Employer Contact _____ Phone _____ Email _____

Physician 1	Physician 2	Physician 3
Name _____	Name _____	Name _____
Phone _____	Phone _____	Phone _____
Address _____ _____	Address _____ _____	Address _____ _____
City _____	City _____	City _____
State _____ Zip _____	State _____ Zip _____	State _____ Zip _____
Is Telehealth available with Physician #1? Yes ___ No ___	Is Telehealth available with Physician #2? Yes ___ No ___	Is Telehealth available with Physician #3? Yes ___ No ___
If yes, web address _____	If yes, web address _____	If yes, web address _____
(Optional) Telehealth-Only Physician 4 Name _____ Phone _____ Telehealth Provider email address _____ Web address _____		

TO BE COMPLETED BY THE EMPLOYEE:

I have selected the following physician from the list provided to me by my employer:

Physician Name _____ Appt Date/Time _____

I select: In-person treatment ___ **or** Treatment by Telehealth ___ Were you offered in-person treatment? Yes ___ No ___

Employee Signature _____ Date _____

FORMULARIO C-42

AGENCIA DE INDEMNIZACIÓN LABORAL DE
TENNESSEE



ELECCION DE MEDICO DEL EMPLEADO

Panel Médico

Empleador

- Indique al menos tres médicos y proporcione este panel al empleado siempre que haya informe de una lesión laboral.
- Mantenga el formulario original completado en sus archivos y envíe una copia al empleado para su constancia.
 - No envíe este formulario al Estado, a menos que se lo solicite.

Empleado

- Llene la parte inferior de este formulario para indicar el médico de su elección.
 - Si se niega a aceptar los servicios médicos del doctor elegido, esto podría conllevar a retrasos en sus derechos a beneficios.
 - ¿Tiene que viajar más de 15 millas (ida o vuelta) a (o desde) el tratamiento médico? Los empleados pueden solicitar reembolso de sus gastos de viaje de la aseguradora.
- **Envíe** el formulario completado **a su empleador**.

A SER COMPLETADO POR EL EMPLEADOR:

Nombre del empleado _____ Fecha en que se proporcionó el panel _____

Empleador _____ Fecha de la lesión _____

Contacto del empleador _____ Teléfono _____ Correo electrónico _____

Médico 1	Médico 2	Médico 3
Nombre _____	Nombre _____	Nombre _____
Teléfono _____	Teléfono _____	Teléfono _____
Dirección _____ _____	Dirección _____ _____	Dirección _____ _____
Ciudad _____	Ciudad _____	Ciudad _____
Estado _____ Código postal _____	Estado _____ Código postal _____	Estado _____ Código postal _____
¿El médico #1 usa Telesalud? Sí _____ No _____	¿El médico #2 usa Telesalud? Sí _____ No _____	¿El médico #3 usa Telesalud? Sí _____ No _____
En caso afirmativo, sitio web _____	En caso afirmativo, sitio web _____	En caso afirmativo, sitio web _____
(Opcional) Telesalud solamente Médico 4 Nombre _____ Teléfono _____		
Dirección de correo electrónico del proveedor de Telesalud _____ Sitio web _____		

A SER COMPLETADO POR EL EMPLEADO:

He seleccionado el siguiente médico de la lista que me proporcionó mi empleador:

Nombre del médico _____ Fecha/Hora de la cita _____

Yo selecciono: Tratamiento en persona _____ tratamiento por Telesalud _____

¿Se le ofreció tratamiento en persona? Sí _____ No _____

Firma del empleado _____ Fecha _____