2nd EDITION

WORKERS' COMPENSATION REFERENCE MANUAL

A Guide to Workers' Compensation Self-Insurance Fund in Georgia

GEORGIA MUNICIPAL ASSOCIATION

www.gacities.com

GMA Workers' Compensation Self-Insurance Fund (GMA WCSIF)

◆ CONTACT LIST ◆

For Reporting of New Claims, Please Contact:

CorVel Reporting Line: (24 hours)	**1-800-685-4267 option 2**
Fax: (24 hours)	**1-866-777-1668**
Email:	fnol_fax@corvel.com
24/7 Nurse Advocacy Line	**1-800-685-4267 option 1**

For Claims Questions Please Contact: **1-800-685-4267 (outside metro Atlanta area)**

Corvel Claims Office
P.O. Box 3279
Duluth, GA
30096
800-685-4267 (toll free)
770-225-5941 (billing inquires)

For general questions or to request a certificate of coverage, please contact: 1-888-488-4462 (outside metro Atlanta)

Jan Hoard, WC Claims Manager & Services Coordinator *jhoard@gacities.com*	**404-313-7285**	**678-686-6251**
Aviva Kerven, Risk Management Specialist *akerven@gacities.com*	**678-688-7821**	**678-688-7821**
Stan Deese, Director, Risk Management Services *sdeese@gacities.com*	**678-686-6221**	**678-686-6321**

For billing and accounting questions, please contact: 1-888-488-4462 (outside metro Atlanta)

Joel Levy, Accounting Technician (deductible billing inq.) *jlevy@gacities.com*	**678-686-6233**	**678-686-6333**

Georgia Municipal Association
PO Box 105377
Atlanta, Georgia 30348
404-688-0472 (phone)
www.gacities.com

24/7 Nurse Advocacy Call Line & Telehealth

Corvel offers a nurse triage call center for GMA members 24 hours a day, 7 days a week.

At the time of an injury, an injured employee can call 800-685-4267 and press #1 to speak with a triage nurse who specializes in occupational injuries. The nurse will evaluate the scope of the injury, determine the immediate medical needs of the injured employee, and make a recommendation for self-care (first aid) or medical evaluation.

The 24/7 Nurse Advocacy line is for **new injuries only**. Any subsequent medical questions or requests should be made directly to the adjuster assigned to the case.

In cases where self-care is recommended, the triage nurse will make sure the injured worker understands and is comfortable with the recommendation and then follow up with the employee within 24 hours to check on the status of their injury.

If the injured employee requires medical treatment, the triage nurse will offer telehealth or contact the nearest medical provider from your panel and make arrangements for the employee's visit. If the providers on your panel are closed for the day, the nurse will offer telehealth or direct the injured employee to the nearest urgent care facility. In the case of a serious injury, please immediately direct your employee to the nearest emergency room. The nurse will fax the facility a one-time treatment authorization and provide your employee with first fill pharmacy information via text or email.

About Telehealth
Telehealth is a new feature that is being offered to GMA WCSIF members as part of CorVel's Enterprise Comp solution. It provides a convenient way for injured workers to get connected immediately with a doctor from a mobile device or computer.

How it Works
At the time of a workplace injury, employees call and speak with a registered nurse through CorVel's 24/7 nurse hotline at 800-685-4267. The nurse will evaluate the injury to determine immediate medical needs. By addressing the injury when it first occurs, CorVel can provide quick and timely care for employees.

CorVel's nurses are trained to provide an initial assessment and will provide an immediate referral to a medical care facility when the injury is severe or if an employee prefers an in-person visit. When the injury is appropriate for a virtual visit, the nurse will offer to refer the employee for a live video conference with a physician. The CorVel nurse will email a link with instructions directly to the injured worker. The CorVel nurse will stay on the telephone with the injured worker until they are connected to the online visit.

All the employee needs for a virtual visit is an email address, smartphone, tablet or computer with a good internet connection. If the employee does not have an email address, CorVel will help them create one.

Advantages of Telehealth

For many workplace injuries, immediate treatment is received through a virtual visit with a doctor eliminating the need for scheduling and attending an in-person appointment. No driving to a doctor's office missed appointments or delays in waiting rooms. With the advent of new technologies, many have been using mobile conferencing in other aspects of their daily activities, so many welcome the convenience of a virtual visit with a doctor and the added expediency of prescriptions and physical therapy schedule. By connecting our employees with appropriate, quality care, it can help prevent a minor injury from becoming a complicated injury and focuses on returning your employee to wellness. Telehealth reduces the lag time from when the injury occurred to when receipt of treatment from hours or days to just minutes, which helps the employee get back at work, healthy and happy.

The physicians providing Telehealth services have contracted with CorVel and average 15 years in primary and urgent care experience, and are US Board Certified, licensed, and credentialed.

While we highly recommend your employees take advantage of the 24/7 Nurse Advocacy/Telehealth program, please understand usage is not mandatory. It is your decision as an employer as to whether to offer your injured employees the 24/7 Nurse Advocacy program. It is also your decision as to whether the employee can call the nurse independently or if you require a manager to be present when the employee speaks with the nurse.

The 24/7 Nurse Advocacy line is also not associated with reporting a new claim or as a replacement for completing the First Notice of Loss (FNOL). As an employer, you still must report the new claim even if your employee has spoken with a triage nurse. If you prefer to call in the claim, you may call the same number (800-685-4267), but choose option #2 to report the claim. You may also report the claim via email to **FNOL_Fax@CORVEL.COM** or fax the FNOL form to 866-777-1668.

Again, we encourage members of GMA WCSIF to take advantage of the 24/7 Nurse Advocacy line. Studies show that use of a triage nurse improves the outcome of claims, and it also removes some of the responsibility from the employer in making medical decisions for your employee. Most importantly, the program is meant to help your injured employee and promote an environment of care and concern.

GEORGIA MUNICIPAL ASSOCIATION
CLAIMS REPORTING INSTRUCTIONS
WORKERS COMPENSATION DEPARTMENT

Claims Center:
CorVel Corporation: 1-800-685-4267
P.O. Box 3279, Duluth, GA 30096

The GMA Workers' Compensation Self-Insurance (GMA WCSIF) Board of Trustees has made available to the members 3 methods for reporting your claim.

To report a Workers' Compensation claim to CorVel Corp. you may choose one of the following:

1. **To speak with a Nurse, call the toll-free number 1-800-685-4267 select option 1-(24/7)**
2. **To report a claim, call the toll-free number 1-800-685-4267 select option 2- (24/7)**
3. **Fax a completed First Report of Injury Form (FROI) to 1-866-777-1668.**
4. **E-Mail the completed First Report of Injury Notice to FNOL_FAX@CORVEL.COM**

Please have available the demographic information of the injured employee along with any information you can provide regarding his/her injury or illness, the medical facility where they were taken, and the severity of the injury as known to you at that time.

If you would like this form in a MSWORD document, please go to GMA's website www.gmanet.com and the FNOL form is available under workers compensation forms.

Please know we make every effort to review and provide you any information regarding your claims in a timely and efficient manner. If you have any problems with the submission or require additional information, please contact Jan Hoard, Claims Liaison at GMA at jhoard@gacities.com or 404-313-7285.

Best Practices
Proper Claim Reporting for Employers

The success of the claims handling process depends largely on the employer's representative who is reporting information to the claims adjuster handling the workers' compensation claim. Timeliness and efficiency in furnishing required information promotes a high level of service to the injured worker and compliance with governing state statutes.

Reporting the Injury

Best Practices:

A. The supervisor should take the time to handle the injury properly – listen to the employee describe the injury and how it occurred. The injured employee should be the supervisor's only concern!

B. If the employee needs emergency care, be sure he is transported to the nearest emergency care center and go with him. If the supervisor cannot go with the injured employee, please call the hospital and provide the WC information.

C. Otherwise, remind the employee to obtain medical care through the "Panel of Physicians" and assist the employee in obtaining care.

D. Report the injury to the insurance adjuster who will handle the claim, either by calling a central telephonic reporting number established by the claim office, or by completing the Form WC1 – Employers' First Report of Injury.

E. Complete a WC-6 (wage statement) with the employee's wages for the 13 weeks immediately prior to the accident. If the employee has not worked substantially the whole 13 weeks, use the wages of a similar employee. Never hold the WC-1 while waiting to obtain wage information. Forward the WC-1 First Report of Injury immediately to the claims office and use the State Board Form WC-6 Wage Statement, to report the wages at a later time to the claims office.

F. Attach a list of the Panel of Physicians posted at the work site.

G. Advise lost time status, but follow-up with specific information, especially if the employee loses more than seven days from work.

Benefits:

A. Gives personal attention at a time of great need.
B. Establishes clear communication with the emergency center.
C. Prevents misunderstanding of unauthorized medical care.
D. Allows the adjuster to act quickly on the case and authorize medical care or additional action.
E. Assures the correct compensation rate will be paid.

F. Assures prompt payment of the first indemnity check.
G. Assists the adjuster in obtaining necessary medical information quickly.

Injury Review

Best Practices:

A. Investigate the accident and make notes of any pertinent information:
1. How did it happen?
2. Who saw it happen?
3. How could it have been avoided?

B. Report any recommendations to the Safety Committee for consideration in improving a Safe Work Site.

C. Advise the workers' compensation adjuster of any prior medical conditions or third party involved in the accident. Be sure to include specifics as reimbursements may be sought through subrogation action.

D. If you suspect fraud or misconduct, do not publicize it; immediately notify the claims office or third party administrator.

E. Immediately notify the claims office or third party administrator whether or not salary will continue in lieu of benefits.

F. Advise the workers' compensation adjuster immediately if an attorney contacts you or you have information that an attorney has become involved. The adjuster will furnish assistance in communications with the attorney.

Benefits:
A. Early investigation is critical in obtaining accurate information, establishing events, identifying witnesses and conditions which may be valuable information in the future.
B. Assures the future safety of employees in the unit.
C. Reimbursement from subrogation saves claim expenses.
D. Maintain the supervisor/employee relationship while allowing a more impartial source to obtain critical and pertinent claim information.
E. Furnishes expert advice and assistance in dealing with legal matters.

Follow-Up Reporting

Best Practices:

A. Keep the adjuster fully advised of lost-time status of the injured employee and whether or not salary will continue in lieu of benefits.

B. Advise of any other employer-provided disability benefit for which the employee qualifies.

C. Check with the treating physician periodically relating to the specifics of disability and limitations.

D. If the physician releases the employee to work, but with limitations, review job duties to make sure they are consistent with restrictions. Please advise the workers' compensation adjuster if an offer of transitional (light) duty can be extended to the employee. The adjuster will assist with medical documentation and reporting requirements. Refer to Board Rule 240, of the Georgia Workers' Compensation Laws, Rules and Regulations Annotated – 2007.

E. Assist the employee with submitting all medical bills, prescription bills and mileage reimbursement requests to the workers' compensation adjuster. Check with the adjuster as to specific forms which may be required.

F. Call the employee frequently during the recovery period to check progress, and alert the workers' compensation adjuster of any concerns expressed by the employee so issues can be handled early.

G. Advise the adjuster immediately upon the employee's return to work, either to full duty or to transitional (light) duty.

Benefits:
A. Assures accurate indemnity payments.
B. Certain employers' contributions may qualify for offsets against part of the indemnity payments.
C. Establishes accurate communication regarding the injury and the requirements of the job.
D. Early return to work is good for all parties concerned. An Early Return-To-Work Program manual is available on the Board's website, www.sbwc.georgia.gov.
E. Assures proper compliance with all filing requirements and relieves confusion.
F. Allows action to be taken by the workers' compensation adjuster quickly, giving the employee confidence in the manner in which the claim is handled.
G. Eliminates overpayment of indemnity benefits.

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.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	❑ Male ❑ Female	Birthdate	Phone Number	Employee E-mail
Mailing Address		City	State	Zip Code
EMPLOYER	Name	NAICS Code	Nature of Business (Trade, Transport, Mfg.,etc.)	
Mailing 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.)	Mailing 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

Upon receipt of this form, check to see that it is complete and accurate. Be sure to list the correct Insurance Company and their SBWC ID number.

Complete Section B, Co or D and file with the Board and send a copy of both sides of the form to the employee and all counsel of record within 21 days of the employer's knowledge of disability, injury or death.

Section B is completed when indemnity benefits are paid or due, including salary in lieu.

Section C is completed when claim is controverted in full or in part.

Section D is completed when no indemnity benefits are due and/or have NOT been controverted.

Form WC-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

EMPLOYEE'S STATEMENT OF INJURY

Name:		**Address:**		
Phone Number:	**Social Security No:**	**Date of Birth:**	**Place of Birth:**	**Married/Single:**
Height:	**Weight:**	**Color of Hair:**	**Any Physical Disabilities:** **Yes_____** **No_____**	**No. of Dependents:**
Describe Previous Disabilities/Injuries, Surgeries etc.:				
Employer:		**Address:**		
Hire Date:	**Job Title:**	**Hours Per Day:**	**Scheduled Off Days:**	**Supervisors Name & Phone Number:**
Describe Your Job:				
Salary/Hourly Rate:		**Average Weekly Wage:**		
Date of Accident/Injury:	**Place of Accident:**	**Time of Day Accident Occurred:** **AM PM**		
How Did the Accident/Injury Happen? (please be specific):				
Name, Address and Phone Number of Witnesses, if any:				
What part of your body was injured:				
Have you ever injured this part of your body before? **Yes _____ No _____**		**If so, When & Where?**		
Name, Address and Phone Number of Family Physician:				

Date: _____ **Signed:** _____

Notice of Workers' Compensation Procedures

This is to certify that I have read and that the use of these forms has been explained to be and that I understand the necessity of the **Workers' Compensation PANEL OF PHYSICIANS notice.**

I understand that when I am involved in an on-the-job injury or sustained an employment related illness that my employer will pay medical costs for treatment by the physician(s) I select from the Panel of Physicians. If I desire to obtain medical services from a physician not listed on the Panel, (which is my right) however, I will be liable for those medical expenses. The physician selected from the Panel of Physicians may arrange for appropriate consultations, referrals, and other specialized medical services as the nature of the injury or illness requires. If I am dissatisfied with my first choice of the panel physician I selected, I may make one change without permission to a second physician also listed on the Panel. However, any further changes require the permission of the employer/insurer, self-insurer claims office, or the State Board of Workers' Compensation. In addition, upon notification by the employer or its administrator, an Independent Medical Examination may be scheduled for me as set forth by the law.

In the case of a bona-fide emergency involving severe injury or illness, or when a Panel of Physicians is not available, I should seek medical care from the nearest Hospital Emergency Room. However, all follow-up care must, thereafter, be rendered by a physician from the Panel, or a Panel Physician's referral.

I further understand that I must notify my immediate supervisor, a member of the departments administrative staff or the Personnel Office immediately after the injury or illness occurs, regardless of the extent of the injury, and when possible prior to seeking treatment. I understand that the treating physician will verify my employment and eligibility for treatment with my employer before commencing treatment unless the nature of the injury so prohibits. Delay in notification may result in denial of payment for medical services rendered**.**

(Please print name)

(Signature of Employee)_____**Date:**_____

(Signature of Employer)_____**Date:**_____

(This notice must be posted in a conspicuous place readily accessible to the employee at all times.)

PANEL OF PHYSICIANS

OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days (see O.C.G.A. § 34-9-80).

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least six physicians, including an orthopedic surgeon with no more than two physicians from industrial clinics (see O.C.G.A. § 34-9-201). Further, this panel shall include one minority physician, whenever feasible (see Rule 201 for definition of minority physician). The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change to another doctor from the list may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

The insurance company providing coverage for this business under the Workers' Compensation Law is:

_____
Insurer Name

_____
address phone

PHYSICIANS' NAMES

name/address/phone	name/address/phone	name/address/phone
name/address/phone	name/address/phone	name/address/phone

(Additional doctors may be added on a separate sheet)

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT https://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).

WC-P1 (7/2022)

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

BILL OF RIGHTS FOR THE INJURED WORKER

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

Employee's Rights

1. **If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.**

2. **Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.**

3. **Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job. All injuries occurring on or before June 30, 2013 shall be entitled to lifetime medical benefits. If your accident occurred on or after July 1, 2013 medical treatment shall be limited to a maximum of 400 weeks from the accident date. If your injury is catastrophic in nature you may be entitled to lifetime medical benefits.**

4. **You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.**

5. **Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than $725 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-0849.**

6. **In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than $725 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more than $483 per week, not to exceed 350 weeks.**

7. **When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than $483 per week for no longer than 350 weeks.**

8. **Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to $7,500 and two-thirds of your average weekly wage, but not more than $725 per week. A widowed spouse with no children will be paid a maximum of $290,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.**

9. **If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.**

Employee's Responsibilities

1. **You should follow written rules of safety and other reasonable policies and procedures of the employer.**

2. **You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of the benefits.**

3. **An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.**

4. **No compensation shall be allowed for an injury or death due to the employee's willful misconduct.**

5. **You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.**

6. **A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.**

7. **You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when you were injured. If you do not attempt the job, your benefits may be suspended.**

8. **If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.**

9. **If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.**

10. **Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.**

11. **If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.**

12. **You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than $10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.**

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: https://www.sbwc.georgia.gov. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777 or 1-800-237-2629.

WC-207 AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

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	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(l) 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

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

WAGE STATEMENT

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE		Mailing Address		
E-mail Address		City	State	Zip Code
EMPLOYER	Name	Mailing Address		
E-mail Address		City	State	Zip Code
INSURER/ SELF-INSURER	Name			
CLAIMS OFFICE	Name	Mailing Address		
SBWC ID #	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

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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Injured Worker's First Fill Prescription Form

NOTICE TO INJURED WORKER & PHARMACIST:

This temporary First Fill card is only valid if used within 30 days of the reported date of injury. Temporary eligibility through this program allows for a one time fill of prescription medications. For assistance processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.**

Injured Worker's Name: _____

SS#: _____ ***Date of Injury:*** _____

INJURED WORKER INSTRUCTIONS:

On your first Pharmacy visit, **please give this notice to any pharmacy listed on this insert to expedite the processing of your approved Workers' Compensation prescriptions, based on the parameters established by Georgia Municipal Association.** With the CorVel pharmacy program, you do not need to complete any paperwork or claim forms. Simply present this CorVel First Fill Prescription Form to the pharmacy. You should not incur any costs or co-pays at the pharmacy and you will be allowed up to a **14** day supply of medications.

PHARMACIST INSTRUCTIONS:

For assistance processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.**
Please use the BIN, PCN, and RxGroup number below to process an online/electronic claim to CorVel:

CORVEL CVS CAREMARK

BIN:	**004336**
PCN:	**ADV**
RxGroup:	**RXFFWC8738587**
Member ID:	**See below to generate ID**

To Generate Member ID: The Injured Worker's 9 digit Social Security Number plus 8 digit Date of Injury will be used as their 17 digit **Member Identification number** when processing their First Fill Prescription:
XXXXXXXXXMMDDYYYY

There are over 72,000 Participating Pharmacies in the CorVel Network. Below is a sample listing. Call (800)563-8438 for a participating pharmacy near you.

CostCo Pharmacy	H.E.B. Pharmacies	Meijer Pharmacy	Smith's Food & Drug Centers
CVS	Hy-Vee Pharmacy	Publix Pharmacy	Target Pharmacy
Dominick's Finer Foods	Ingles Pharmacy	Raley's Drug Center	Von's Pharmacy
Drug Mart	Kroger Pharmacy	Rite Aid Pharmacy	Wal-Mart Pharmacy
Fred's Pharmacy	Longs Drug Store	Safeway Pharmacy	Walgreens Pharmacy
Giant Eagle Pharmacy	Marc's Pharmacy	Sav-On Drug Store	Wegman Pharmacy
Giant Food Stores, LLC	Medicine Shoppe	Shoprite Supermarkets	Winn Dixie Pharmacy

CORVEL

AUTHORIZATION FOR MEDICAL TREATMENT

PLEASE RENDER TREATMENT AS MAY BE REQUIRED:

_____

EMPLOYEE'S NAME

PLEASE NOTE: ANY TREATMENT OR DIAGNOSTIC SERVICE PERFORMED OUTSIDE YOUR FACILITY MUST BE PRE-APPROVED BY:

CorVel Corporation
P.O. Box 3279
Duluth, Ga 30096
678-942-7300
Bill Inquiries: 770-225-5941 Fax: 866-434-4759 Email: Duluth_bill_review@corvel.com

_____

Signature of Claims Adjuster approving initial treatment **Date**

BASED UPON THE CURRENT EVALUATION, THE EMPLOYEE CAN PERFORM THE FOLLOWING WORK:

FOR PHYSICIAN:

WORK RESTRICTIONS

_____ **NORMAL –** NO RESTRICTIONS

_____ **MEDIUM –** LIFTING UP TO FIFTY (50) POUNDS MAXIMUM WITH FREQUENT LIFTING AND/OR CARRYING OF OBJECTS WEIGHTING UP TO 25 POUNDS.

_____ **LIGHT –** LIFTING OF TWENTY POUNDS MAXIMUM AND CARRYING OF OBJECTS WEIGHING UP TO TEN POUNDS. A JOB IN THIS CATEGORY COULD REQUIRE STANDING OR WALKING TO A SIGNIFICANT DEGREE, PUSHING OR PULLING OF ARM AND LEG CONTROLS.

_____ **SEDENTARY –** LIFTING TEN POUNDS MAXIMUM, LIFTING AND CARRYING OF ARTICLES SUCH AS LEDGERS AND BOOKS. SOME STANDING AND WALKING.

_____ **ADDITIONAL RESTRICTIONS:** _____

_____

DIAGNOSIS: _____

_____

PROGNOSIS: _____

_____

NEXT APPOINTMENT (DATE AND TIME): _____

_____ _____

PHYSICIANS SIGNATURE **DATE**

Georgia Municipal Association
PO Box 105377 • Atlanta, Georgia 30348
404-688-0472 • www.gacities.com