TEXAS

NONSUBSCRIPTION

CLAIMS KIT

CLAIM SERVICES PROVIDED BY:

Anchor Risk and Claims Management

Texas Nonsubscription

Anchor Risk and Claims Management
Texas Nonsubscription

The following information is an Accident Claims Kit that will assist your organization in documenting and obtaining information about an on-the-job injury. Proper completion of these forms will also allow Anchor to have proper information to investigate accidents, as well as, provide us with information so we can help your Employees obtain the proper medical care.

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Anchor Risk and Claims Management
Texas Nonsubscription

Welcome to Anchor Risk and Claims Management

We are excited and looking forward to working directly with your organization. Anchor Risk and Claims Management offers several individualized services, exclusive of or in combination with a complete Claims Administration Program. "We customize our Claim Services to your organization's needs."

HISTORY:
ANCHOR RISK and CLAIMS MANAGEMENT has been handling Non Subscription Claims since 1991. Since that time, Anchor has:

- Handled over 60,000 claims
- Handled and assisted claims for over 5,000 Policyholders
- Worked with and has authority to act as an Authorized Third Party Administrator for Multiple NonSubscription Insurance Carriers

Anchor prides itself in being the Industry's most well versed and knowledgeable Claims Administrator in the Non Subscription marketplace. Our expertise in not only Benefit Claims Administration, but in many other areas of claims handling, puts us in a position that our competitors just cannot match.

We have extensive knowledge in interpreting and applying the Insurance Policy Form and with our years of "hands on" experience in mediations, trials, and arbitrations, we can provide our customers with expert advice on litigated matters.

BYRON MCBRIDE
MANAGER
ANCHOR RISK CLAIMS MANAGEMENT
14785 Preston Road, Suite 350
Dallas, TX 75254
www.anchor-risk.com

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TEAM CONTACT INFORMATION

14785 Preston Rd. Suite 350
Dallas, TX 75254
Phone: 800-275-3193
Fax: 800-275-3194

STAFF	TITLE	EXTENSION
Lynn Berg	President	607
Byron McBride	Claims Manager (NS)	543
Craig Hutson	Claims Supervisor	542
Argelia Castanon	Senior Claims Adjuster	537
Deborah Harvey	Senior Claims Adjuster	540
Alberto Bravo	Senior Claims Adjuster	535
Julisa Tarfaoui	Senior Claims Adjuster	549
Toni Burnett	Senior Claims Adjuster	538
Sue Powell	Claims Adjuster	546
Austin Bauer	Claims Adjuster	533
Diane Burkham	Senior Claims Tech.	536

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www.anchor-risk.com

Additional information, forms, updates, and links to other applicable websites can be located on our website.

Anchor believes in the integrity of its work product and communication with our customers. We want to put information at your fingertips so we have created an on-line system to allow you to view claim activity. This system can be accessed through our website.

"The INSURED SYSTEM"

- Allows our Customers to report a Claim on-line
- View Adjuster notes
- View all Claim file documents (Medical reports/bills/correspondence)
- Review Financials: Payments and reserves
- Print and Review Explanation of Review (document showing Medical Audit results)
- Create Ad-hoc Claim reports and loss runs
- All information is "real-time", no delay on obtaining information.
- No limit and/or costs for additional Users
- Security: Each User is given their own USER ID and PASSWORD

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Medical Bill Review/Audit Process

Anchor Claims performs an audit and review on all medical bills submitted on a claim. Bill Review is completed in our office through professional auditing software that is currently utilized by several large medical bill re-pricing companies.

- All completed “in house” at the Anchor Dallas Claims office
- All bills audited down to usual/customary: defined as Texas Workers Compensation Fee Schedule, i.e. 125% Medicare accepted rate
- Additional audit feature: All bills after initial audit are then processed through the Rockport PPO network to find additional savings. On average 2-3% additional savings is produced
- Current savings of 40%+ on average on audited/reviewed medical bills.
- No charge if no savings is produced when a bill is audited/reviewed.
- Negotiate fee agreements with medical providers
- Explanation of Review is generated on every medical bill (regardless of savings/reduction)

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GUIDELINES FOR CLAIMS REPORTING

When an accident occurs (or any incident reported by an Employee as being work related):

1) Take care of the Employee and make sure they receive proper care. You should always ask the Employee if they would like to see a physician for their injury. If they decline have them complete the OFFER OF MEDICAL TREATMENT DECLINED form.

2) Obtain as much information as you can from the Injured Employee. Complete the EMPLOYER'S FIRST REPORT OF INJURY form and have the Employee complete the EMPLOYE STATEMENT AND INFORMATION form.

3) Have the Manager or Employee's direct supervisor complete the SUPERVISOR'S ACCIDENT INVESTIGATION REPORT. Make sure all witnesses are listed. If possible have the witnesses complete the WITNESS STATEMENT form.

4) You can electronically submit the claim to ACM by utilizing the First Reporting System on our website: www.anchor-risk.com

5) Once you have all the forms completed, you may fax, mail, and/or email them to:

ANCHOR RISK and CLAIMS MANAGEMENT
P.O. BOX 819045
DALLAS, TX 75381-9045
800-275-3193
FAX: 800-275-3194

6) We request that any accident involving serious injury, death, and/or any severe accident please notify Anchor immediately by phone.

7) Anchor Claims Management requests that you send all medical bills to our attention for review. This will allow us to ensure that you are only paying/charged for Reasonable and Necessary rates. If the bill is within your Self Insured Retention, we will audit the bill and advise what amounts should be paid.

8) Our office hours are from 8:00-5:00pm. Should you have any questions or comments, please do not hesitate to contact us.

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EMPLOYER'S FIRST REPORT OF INJURY

Employer:		Policy Number:
Address:		
Phone Number:		Facsimile Number:
Employer Contact:		Employer Contact Phone Number or email:
Employee's Name		
Social Security Number	Date of Birth:	Sex: ☐ Male ☐ Female
Race/Ethnic Identification (per/for DWC-7) ☐ White ☐ African-American ☐ Hispanic ☐ Asian ☐ Other: _____		
Employee's Address		
City	State & Zip	Home Phone:
Job Title	Date of Hire	Department
Date of Injury	Date Reported by Employee:	
Location of Injury (check one): ☐ Primary Business location ☐ Off site location ☐ during travel		
Description of Accident:		
Losing time from work? Y ☐ N ☐		Date lost time began:
Time of Injury a.m. ☐ p.m.☐		Rate of Pay $_____Hourly ☐ Salary ☐
Avg # of Hours Worked per Week		Speaks English Y ☐ N ☐ Preferred Language:
Medical Attention required: (if so, name of facility and phone number:		
Signed/Completed by:	Position/Title:	Date:

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EMPLOYEE STATEMENT AND INFORMATION

(TO BE COMPLETED BY THE EMPLOYEE)

Employee's Name	
Date of Birth:	Social Security Number:
Street Address	
State & Zip	Home Phone:
Email Address:	Job Position/Title:
Date of Hire	Department
Direct Supervisor	Normal Work Schedule (Days of the Week)
Average Hours Worked Per Week	Rate of Pay

Accident Details: How where you injured?		
What job where you performing at the time of the accident?		
List the exact Injuries you sustained and to what part of your body? List all injuries.		
Who did you report this injury to?	When did you report it (Date and Time)	
Were there any witnesses to this event? If so, please list their names.		
Print Name	Signature	Date
I certify that by executing and signing this document that this is a true and accurate report of the circumstances which occurred on the date of my injury/accident listed above.		

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SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Employee's Name	Social Security Number:	Date of Birth
Employee's Job Position/Title:	Date of Hire:	
Employee's Direct Supervisor:		
Date of Accident:	Time of Accident:	On Insured's premises: Y or N
To Whom did the Employee report the Accident to?		
When was the Accident Reported? (include Date and Time) :		
Actual location of accident (physical location on Insured's premises or address if accident off site)		
List any/all witnesses to accident: Name: Address: Phone: Name: Address: Phone: Name: Address: Phone:		
Was Employee taken for Medical Care? Y or N	Taken by: Employer or On his own (Circle)	
Did the Employee lose time from work? Y or N	Date Returned to Work:	
Describe the Accident Details as they were first reported to you		
Name of Medical Provider (include Address/Phone if possible		
Signed/Completed by:	Position/Title:	Date:

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WITNESS STATEMENT

Name of Witness:	Date of Incident:
Name of Injured employee:	
Address:	Telephone Number:
Same Employer as injured employee? Y or N If not, employed by: Employer's telephone number:	
Are you related to the injured employee? Y o N	If "YES", how?
Please stated the date and time of the injury:	
Did you actually see this injury happen? Y or N If "NO", how do you know about it?	
How near to the injured employee were you at the time of the injury?	
Please explain in detail what you know about this incident:	
Did this employee ever talk with you about getting hurt on the job? Y or N If "YES", what was the date and time this conversation took place? What did the employee say?	
Do you know of any other injury, accident, or illness this employee has had? Y or N If "YES", please explain:	
Give the names of any other persons who might know about this accident/ injury: _____ _____ _____ _____ _____ _____	
Additional comments:	
<u>To the best of my knowledge, this statement is true and correct.</u>	
Signature of Witness:	Date Signed:

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OFFER OF MEDICAL TREATMENT DECLINED

Employee's Name	Social Security Number:	Date of Birth

I, _____ understand that my Employer does not have Workers Compensation Insurance Coverage. I understand they are a Non Subscriber to the Workers Compensation Act. I further understand they have an EMPLOYEE INJURY BENEFIT PLAN, that is afforded to all their Employees and I have been advised and understand the Benefits and obligations under this Plan.

I, _____ understand and acknowledge that my Employer has offered and extended me the ability to seek medical attention for my injury. By executing this document I understand that I am declining to accept these services and benefit offered by my Employer.

I, _____ understand that by declining these medical services that my Employer will not be responsible for any medical care that I seek on my own. Unless my Employer specifically directs and/or pre-approves this medical care on my behalf.

Print Name of Employee	Signature of Employee	Date

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RELEASE OF HEALTH RECORDS AUTHORIZATION

NAME OF ASSOCIATE: _____ **Accident Date:** _____

I_____, authorize the disclosure of my protected health information[1] as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws[2], subsequent disclosure by such person(s) or organization(s) may not be protected by those laws. I further authorize the release of employment, governmental, insurance company, or other records or information.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information to any designated Claims Administrator or Committee member for the _____ Plan (the "Benefit Plan") and/or
   Anchor Risk and Claims Management (acting Claims Administrator for Benefit Plan)
   PO Box 819045
   Dallas, TX 75381

2. Specific description of the protected health information that I authorize for disclosure:

   Any and all records regarding my health, including medical histories, consultations, examinations, prescriptions, diagnosis, tests, reports or treatments. I further specifically authorize the disclosure of psychotherapy notes, if any. I further authorize the release of employment, governmental, insurance company, or other records or information.

3. This information may be used by the Claims Administrator or Committee Member to evaluate, adjust, describe, or report matters about my health to persons entitled to receive this information.

4. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) names above have taken action in reliance on this authorization.

5. This authorization expires Five years from the date of this authorization, or the date that my Benefit Claims expires, whichever occurs first.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

_____ _____
Signature of Employee: Date:

Employee Printed Name: _____

Employee Address: _____

Employee Date of Birth: _____ Employee Social Security number: _____

[1] Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to 1)the past, present, or future physical or mental health of an individual; 2)the provision of health care to an individual; or 3)the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R 164.508.

[2] These laws apply to health plans, health care providers, and health care clearinghouses.

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AUTHORIZATION FOR INITIAL TREATMENT AND PRESCRIPTION SERVICES

Employee Name (please print)
Social Security #

The above-referenced employee has reported sustaining an occupational injury/illness. **You are authorized** to provide medically necessary treatment and/or prescription services for conditions related to the reported injury/illness. Inasmuch as this company does not provide workers' compensation insurance benefits for employee injuries, only this company can authorize the payment for costs of examination and treatment. In the opinion of the physician, should it become necessary to refer to additional healthcare providers, i.e., other physicians, clinics, hospitals, therapists or any other healthcare person or group, please furnish such opinion/information to this company's authorized contact (noted above) prior to any further treatment.

_____(Company) has a drug-free work force policy and requires a urine-based drug screen for all employees requiring medical treatment for an occupational injury/illness. Please conduct a drug screen for your panel of controlled substances, in addition to treating the occupational injury/illness. The results of the drug screen must be reported only to the above company contact.

Your charges for medically necessary services will be paid by Anchor Risk Management To facilitate prompt payment, submit your billing document and a copy of any medical documentation to:

Anchor Risk Management
P.O. Box 819045, Dallas, TX 75381
Fax: 800-275-3194
Tel: 1-800-275-3193

Treatment and/or billing inquiries should be directed to the above-noted company contact. For authorization to release medical records and other information relating to the above employee's occupational injury/illness please refer to the back of this form.

_____ _____ _____
Signature for (Employer) Print Name Date

SPANISH

ACCIDENT
&
INVESTIGATION

FORMS

Anchor Risk and Claims Management
Texas Nonsubscription

DECLARACION DE EMPLEADO Y INFORMACION

(SER COMPLETADO POR EL EMPLEADO)

El nombre de empleado	
La fecha del nacimiento	Número del seguro social
Dirección de calle	
Código postal	Número de teléfono
Correo electrónico (la dirección)	La posición del trabajo/titulo
La fecha de empleo	Departamento
Supervisor directo	Horario de trabajo normal (dias de la semana)
Promedio de horas trabajada por semana	Sueldo de Semana y por hora

Detalles del accidente: ¿Cómo se hirió?		
¿Que trabajo estaba realizando en aquel momento del accidente?		
¿Lista las Heridas exactas sostenido y a qué parte de su cuerpo? Lista todas las Heridas.		
¿A quién reporto usted la herida?	Cuando hizo el reporte (la Fecha y el Tiempo)	
¿Hubo testigo al acontecimiento? Si eso es el caso, lista por favor sus nombres.		
Imprima Nombre	Firma	Fecha
Certifico que ejecutando y firmar este documento que esto es un reporte verdadero y exacto de las circunstancias que ocurrieron en la fecha de mi herida/accidente listado arriba.		

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LA INVESTIGACIÓN DE ACCIDENTE DEL SUPERVISOR

Nombre de el empleado	El Número del seguro social:	La fecha del Nacimiento
La Posición del Trabajo del empleado/Titula:	La fecha de Empleo:	
El Supervisor Directo del empleado:		
La fecha de Accidente:	El tiempo de Accidente:	En el local del asegurado: Si o No
¿A Quién reporto el Accidente de el Empleado?		
¿Cuándo fue reportado el Accidente? (Incluya la Fecha y el Tiempo) :		
Actual location de accident (posición física en el local del asegurado o dirección si accidente lejos de sitio)		
Liste todo testigo al accidente: El nombre: La dirección: El teléfono: El nombre: La dirección: El teléfono: El nombre: La dirección: El teléfono:		
¿Fue tomado el Empleado para el Cuidado Médico? Si o No		
Tomado por: El empleador o solo (círcula)		
¿Perdió el Empleado tiempo del trabajo? Si o No	La fecha que Regresó Trabajar:	
El nombre de Proveedor Médico (incluya Dirección/Teléfono si es possible		
Describa en Detalle el Accidente como fue reportado primero a usted		
¿Qué revelo la Investigación fue la causa del accidente?		
En general Comente acerca del Accidente/Acontecimiento:		
Firma/Completado por:	Posicion/Título:	La fecha:

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DECLARACION DE TESTIGO

El nombre de la Compañía:	La fecha de Incidente:
El nombre del Empleado Herido:	El nombre del testigo
La dirección:	El Número telefónico:
¿Mismo empleador como empleado herido? Si o No Si no, empleado por: El número telefónico del empleador:	
¿Es relacionado al empleado herido? Si o No	¿Si "SI", cómo?
¿Cuánto tiempo conoce a este empleado?	
La fecha y el tiempo de la herida. ¿Realmente vio usted esta herida suceder? Si o No ¿Si no, cómo sabe usted de ello?	
¿Que cerca al empleado herido fue usted en aquel momento de la herida?	
Explique por favor con todo detalle lo que usted sabe de este incidente:	
¿Jamás habló este empleado con usted acerca de ser dolido en el trabajo? Si o No ¿Si "SI", cuál fue la fecha y el tiempo que esta conversación sucedió? ¿Qué dijo el empleado?	
¿Sabe de cualquier otra herida, del accidente, o de enfermedad este empleado ha tenido? Si o No Si "SI", explica por favor:	

Dé los nombres de cualquier otras personas que quizás sepan de este accidente/herida: _____ _____ _____ _____ _____ _____	
Los comentarios adicionales:	
<u>Al mejor de mi conocimiento, esta declaración es verdadera y correcta</u>	
La firma del Testigo:	La fecha:

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OFERTA DE TRATAMIENTO MEDICO DECLINADA

El Nombre del empleado	El Número del seguro social:	La fecha del Nacimiento

Yo,_____ comprendo que mi Empleador no tiene Cobertura de Compensación de Trabajadores. Comprendo que son un Non Suscriptor al Acto de la Compensación de Trabajadores. Comprendo aún más que tienen un PLAN de BENEFICIO de HERIDA de EMPLEADO, que es proporcionado a todo Empleados y yo he sido aconsejado y comprendo los Beneficios y las obligaciones bajo este Plan.

Yo,_____ comprendo y reconozco que mi Empleador ha ofrecido y me ha extendido la capacidad de buscar atención médica para mi herida. Ejecutando este documento yo comprendo que declino aceptar estos servicios y los beneficios ofrecidos por mi Empleador.

Yo,_____ comprendo que declino estos servicios médicos que mi Empleador no será responsable de ningún cuidado médico que busco solo. A menos que mi Empleador dirija específicamente y/o pre-aprobe este cuidado médico de mi parte.

Imprima Nombre de Empleado	La firma de Empleado	Fecha

TEXAS DEPARTMENT OF INSURANCE

DIVISION OF WORKERS COMPENSATION
(DWC)

MANDATORY FORMS (**REQUIRED FOR NONSUBSCRIBERS**)

Anchor Risk and Claims Management
Texas Nonsubscription

Dear Valued Customer:

We wish to keep you apprised of industry changes that may be affecting our Non-Subscribing clients. Texas Non Subscribers have always been required to file the DWC-5 & DWC-7 forms with the Texas Department of Insurance – Division of Workers Compensation.

However, in the past, enforcement and/or fines were rarely ever imposed against Non-Subscribers who failed to file these forms. The Texas Department of Insurance has now issued directives for the enforcement of the filing of these forms. Texas law recently changed so that penalties of up to $25,000 per day can be imposed for failing to file these forms.

What is the DWC-5 & DWC-7?

- The DWC-5 is an annual filing requirement for Non-Subscribers that notify the Texas Department of Insurance that your company has opted out of the Workers' Compensation scheme.
- The DWC-7 is a notice of lost time injury, which must be filed during the next calendar month after a lost-time accident. Reporting is required for any accident involving one or more days of days missed by your Employee due to an accident.

Additional information concerning the DWC-5 & DWC-7 forms/filing can be at our website (www.anchor-risk.com) or at the following to DWC sponsored websites:

http://www.tdi.state.tx.us/forms/dwc/dwc005nocov.pdf **or**
http://www.tdi.state.tx.us/forms/dwc/dwc7.pdf

ANCHOR will file the DWC7 with the DWC/TDI on our Customer's behalf. We will forward a copy of the DWC-7 forms at your request.

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION
Records Processing MS-94
7551 Metro Center Drive, Suite 100
Austin, Texas 78744

NON-COVERED EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

REPORT FOR MONTH OF: _____ YEAR: _____

EMPLOYER DATA

1.Employer's Business Name	2. Federal Employer ID No.	3. Telephone No.
4.Employer's Business Mailing Address (Street or P.O. Box)		
5. City / County / State / Zip		
6. Employer's Representative (Print/Type Name and Title of Person Completing Form) Last First MI	7. Employer's Representative's Signature I certify the information provided is correct Date (m-d-y)	

8 NAICS CODES /Employment	
NAICS Codes	NAICS Employment

INJURY DATA

1 Employee's Name (Last / First / MI)

10. Date of Injury/Illness (m-d-y)	11. Employee 6 Digit NAICS code	12. Equipment	13. Nature of INJ/ILL	14. Body Part(s) Affected

15. Social Security Number | 16. Sex ☐M ☐F | 17. DOB (m-d-y)

18. Race/Ethnic Identification
☐ White (not of Hispanic origin) ☐ Hispanic ☐ Asian or Pacific Islander
☐ Black (not of Hispanic origin) ☐ American Indian or Alaskan Native

22. Description of Incident

23. Lost Time ☐ > 1 Day - 7 Days ☐ 8 Days or More

24. Occupational Disease ☐ YES ☐ NO

19. Cause of Injury

20. Location of Injury (see instructions) ☐ A ☐ B ☐ C

21. Employee's Occupation | 21a. Hourly Wage

26. DWC USE ONLY
OCC NAT BOD SRCE ACCDT AOS

25. Fatality ☐ YES ☐ NO
Date (m-d-y)

2 Employee's Name (Last / First / MI)

10. Date of Injury/Illness (m-d-y)	11. Employee 6 Digit NAICS code	12. Equipment	13. Nature of INJ/ILL	14. Body Part(s) Affected

15. Social Security Number | 16. Sex ☐M ☐F | 17. DOB (m-d-y)

18. Race/Ethnic Identification
☐ White (not of Hispanic origin) ☐ Hispanic ☐ Asian or Pacific Islander
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20. Location of Injury (see instructions) ☐ A ☐ B ☐ C

21. Employee's Occupation | 21a. Hourly Wage

26. DWC USE ONLY
OCC NAT BOD SRCE ACCDT AOS

25. Fatality ☐ YES ☐ NO
Date (m-d-y)

Date Stamp