FREEMAN ADMINISTRATIVE SOLUTIONS, INC. (FAS)
P.O. BOX 2309
ADDISON, TX 75001-2309
PHONE: 972-930-9493 OR TOLL FREE 866-930-9493
FAX: 972-930-9479 Or Email: CLAIMS@FASTPA.COM

ACCIDENT REPORTING PROCEDURES

When an injury (or alleged injury) occurs:

- See that the injured employee receives **prompt medical attention,** and complete the initial **"Medical Treatment Authorization"** form, including the "Drug/Alcohol Screen" section. The form is sent with the injured employee to the medical facility.
- Send the employee to an occupational accident medical facility.

Immediately upon notification of an incident:

- Have the injured employee complete and sign the **Employee Statement of Injury** form.
- Have the employee sign the **Medical Record Release Authorization.**
- Complete the **Supervisor's Incident Report**.

Review the forms and make sure they are complete, signed and have your Company Name listed. Make copies of the attached forms for your records and future use.

Immediately upon completion of the forms, **fax** OR **email** them to:

FAX: (972) 930-9479 or E-mail address CLAIMS@FASTPA.COM

Accidents resulting in death or severe injury should be reported *immediately by telephone*.
Call 972-930-9493 or Toll free 1-866-930-9493.

After FAS has received the completed notice and forms, you will be sent an acknowledgement letter. All medical bills should be submitted to FAS for approval and audit prior to payment.

If you should have any questions concerning a claim, do no hesitate to call us at 1-866-930-9493 between 8:00 A.M. and 5:00 P.M. Monday through Friday.

FREEMAN ADMINISTRATIVE SOLUTIONS, INC. (FAS)

Claims Kit

***Includes*:**
Accident Reporting Procedures

FORMS:

EMPLOYEE STATEMENT OF INJURY
SUPERVISORS INCIDENT REPORT
WITNESS STATEMENT
MEDICAL TREATMENT AUTHORIZATION
PHYSICIAN'S REPORT OF EMPLOYEE INJURY
MEDICAL RECORDS RELEASE AUTHORIZATION
DECLINE MEDICAL TREATMENT FORM

REVIEW FOR COMPLETENESS

FAX OR EMAIL REPORT NOTICES TO:

FAS

FAX: (972) 930-9479
Or
CLAIMS@FASTPA.COM

Should you have any questions regarding any of these forms, please contact our office at (866) 930-9493 between 8:00 a.m. and 5:00 p.m., Monday through Friday.

EMPLOYEE STATEMENT OF INJURY

THIS REPORT IS TO BE COMPLETED IN ITS ENTIRETY BY THE EMPLOYEE
Fax or Email this completed form to *FAS (972) 930-9479 or CLAIMS@FASTPA.COM*

EMPLOYER INFORMATION: ____________________

ADDRESS: ____________________ City: ____________________ State TX Zip: ____________

PHONE: (______) ____________ FAX: (______) ____________ Policy# ____________

EMPLOYEE INFORMATION:

NAME ____________________ D.O.B. ____/____/____ **SOCIAL SECURITY NO.** ____________

HOME ADDRESS ____________________

CITY ____________________ STATE ______ ZIP ____________ PHONE (______) ____________

OF DEPENDENTS (IF ANY) ____________ MARITAL STATUS ____________ GENDER ☐ MALE ☐ FEMALE

PREFERRED LANGUAGE IF OTHER THAN ENGLISH ____________________

INJURY INFORMATION

DATE OF INCIDENT ____/____/____ **TIME OF INCIDENT** ____________ ☐ **A.M.** ☐ **P.M.** **DAY OF WEEK** ____________ **TIME WORKSHIFT STARTED** ________ ☐ **A.M.** ☐ **P.M.**

DATE I REPORTED NJURY TO MANAGER ____/____/____ TIME REPORTED ____________ ☐ **A.M.** ☐ **P.M.**

ADDRESS WHERE INJURY OCCURED ____________________ CITY ____________

STATE ________ ZIP ____________ PHONE (______) ____________ FAX (______) ____________

EXACT AREA WHERE INJURED ____________________

DESCRIBE EQUIPMENT INVOLVED (IF ANY) ____________________

____

DESCRIBE WHAT YOU WERE DOING AT TIME OF INCIDENT ____________________

____

DESCRIBE FULLY HOW THE INCIDENT OCCURRED ____________________

____

____

WAS A SAFETY DEVICE APPLICABLE? ☐ YES ☐ NO WAS IT USED? ☐ YES ☐ NO IF YES INDICATE THE DEVICE APPLICABLE ____________________

DESCRIBE NATURE OF INJURY ____________________

____

BODY PART(S) INVOLVED ____________________

HAVE YOU HAD A SAME OR SIMILAR INJURY BEFORE? ☐ YES ☐ NO IF YES, GIVE DETAILS ____________________

____

I, ____________________ (Employee), the undersigned herewith CERTIFY that the foregoing statements and answers on this form are complete and true, and that no information has been omitted, and that I made such statements and answers of my own free will. I understand that my Employer does not carry Workers' Compensation insurance, and furthermore, that any payments to me or anyone else for expenses in connection with this incident and resulting in injury is not an admission of liability on the part of my Employer.

I authorize direct payment to medical providers and others rendering services in connection with this claim.

Employee Signature ____________________ Witness ____________________ Date ____________

Translated by (if applicable) ____________________ Date ____________

Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

SUPERVISORS INCIDENT REPORT

THIS REPORT IS TO BE COMPLETED IN ITS ENTIRETY BY THE EMPLOYER
Fax or Email this completed form to *FAS (972) 930-9479 or CLAIMS@FASTPA.COM*

EMPLOYER NAME: ________________________ Policy#_________________

LOCATION: (If different from above)________________________ LOCATION NO.:____________

DEPARTMENT:__________ JOB TITLE: ____________ DATE OF HIRE: ____/____/____

SCHEDULED DAYS/WEEK: ________ SCHEDULED HOURS/DAY: ________ HOURLY RATE: $________

TIME LOST FROM WORK? YES ☐ NO ☐ FIRST DAY OF LOST TIME: ____/____/____

DATE RETURNED TO ☐ FULL ☐ MODIFIED / DUTY: ____/____/____

EMPLOYEE INFORMATION:

NAME:________________________________ **SOCIAL SECURITY NO**:______________

HOME ADDRESS:____

CITY:________________ STATE: ______ ZIP:__________ PHONE: (______)______________

GENDER ☐ MALE ☐ FEMALE PREFERRED LANGUAGE IF OTHER THAN ENGLISH: ______________

BASIC INJURY INFORMATION

DATE OF INCIDENT: ____/____/____ **DAY OF WEEK:**__________ **TIME OF INCIDENT:**__________ ☐A.M.☐ P.M.

DATE REPORTED INCIDENT: ____/____/____ **DAY OF WEEK:**______ **TIME REPORTED INCIDENT:**______ ☐A.M.☐ P.M.

NAME OF SUPERVISOR WHEN INJURY OCCURRED: ____________________ CONTACT PHONE #: (_____)__________

DESCRIBE NATURE OF THE EMPLOYEE'S INJURY: ________________________________
BODY PART(S) INVOLVED: ____

DESCRIBE EQUIPMENT INVOLVED (IF ANY): ________________________________

WITNESS INFORMATION (IF NONE PLEASE INDICATE NONE)

NAME OF WITNESS:________________________ HOME PHONE: (______)______________

HOME ADDRESS: ____________________ CITY: ______________ STATE: ______ ZIP:________

EMPLOYEE? YES ☐ NO ☐ TITLE:____________ DEPT:__________ WORK PHONE: (_____)__________

NAME OF WITNESS:________________________ HOME PHONE: (______)______________

HOME ADDRESS: ____________________ CITY: ______________ STATE: ______ ZIP:________

EMPLOYEE? YES ☐ NO ☐ TITLE:____________ DEPT:__________ WORK PHONE: (_____)__________

MEDICAL PROVIDER

NAME OF CLINIC/HOSPITAL/PHYSICIAN:________________________________ PHONE:____________

IF NOT A DESIGNATED PROVIDER, PLEASE COMPLETE THE FOLLOWING -

ADDRESS:________________________ CITY:____________ STATE:________ ZIP CODE:__________

SIGNATURE OF SUPERVISOR/MANAGER COMPLETING REPORT

______________________________ ______________________
Supervisor/Manager Name - Printed Phone

X_____________________________ ______________________
Supervisor/Manager Signature Date

WITNESS STATEMENT

Fax or Email this completed form to *FAS (972) 930-9479 or CLAIMS@FASTPA.COM*

EMPLOYER INFORMATION: ______________________________

ADDRESS: ____________________ City: ____________________ State TX Zip: ____________

PHONE: (_____) ______________ FAX: (_____) ______________ Policy# ______________

NAME OF WITNESS ______________________________ HOME PHONE ____________________

HOME ADDRESS ______________________________ CITY ____________________ STATE ___ ZIP ________

TITLE ____________________ DEPT. ____________________ WORK PHONE ____________________

DATE OF INCIDENT ____________________ TIME OF INCIDENT ____________________ A.M. _____ P.M. _____

THIS STATEMENT CONCERNS MY KNOWLEDGE OF THE ALLEGED INCIDENT.

1. NAME OF INJURED EMPLOYEE: ______________________________
2. IF NOT EMPLOYEE, REASON FOR PRESENCE AT LOCATION: ______________________________
3. ARE YOU RELATED TO INJURED EMPLOYEE? ______________________________ HOW? ____________
4. HOW LONG HAVE YOU KNOWN THIS EMPLOYEE? ______________________________
5. PLEASE EXPLAIN IN DETAIL WHAT YOU KNOW ABOUT THIS INCIDENT: (NAME SPECIFIC INDIVIDUALS, OBJECTS OR EQUIPMENT)
6. DID YOU ACTUALLY SEE THE INCIDENT? __________ IF NOT, HOW DID YOU HEAR ABOUT IT? ______________________________
7. DO YOU KNOW OF ANY OTHER INJURY, INCIDENT OR ILLNESS THAT THIS EMPLOYEE HAS HAD? __________ IF SO, EXPLAIN: __________
8. GIVE THE NAMES AND ADDRESSES OF ANY OTHER PERSONS WHO MIGHT KNOW ABOUT THIS INCIDENT:
9. ADDITIONAL COMMENTS: ______________________________

I certify that the foregoing statements and answers on this form are complete and true, and that no information has been omitted.

Witness: ______________________________ Verified by: ______________________________
Signature Signature
Date: ______________________________ Date: ______________________________

Translated By (If Applicable): ______________________________ Date: ____________________

Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

MEDICAL TREATMENT AUTHORIZATION

THIS REPORT IS TO BE COMPLETED IN ITS ENTIRETY BY THE EMPLOYER
Fax or Email this completed form to *FAS (972) 930-9479* or *CLAIMS@FASTPA.COM*

EMPLOYER INFORMATION: ______________________________

ADDRESS: ______________________ City: ______________________ State TX Zip: ______________

PHONE: (_______) ______________________ FAX: (_____) ______________________ Policy# ______________

INJURED EMPLOYEE: ______________________ **Social Security Number:** ______________________

To: Approved Provider

The above referenced employee has reported sustaining an occupational injury/illness related to his or her employment. You are authorized to provide medically necessary treatment and/or prescription services for conditions related to the reported injury/illness.

Type of Injury ____

Your charges for medically necessary services will be paid directly by the Employer. To facilitate prompt payment, submit your billing document and a copy of the Report (physicians only) to:

FAS
P O BOX 2309
Addison, Texas 75001

Treatment and billing inquiries should be directed to *FAS, Inc.* at (866) 930-9493. For authorization to release medical records and other information relating to the above employee's occupational injury/illness, refer to Medical Records Release Authorization.

❐ Drug /❐ Alcohol **Screen Required** ❐ **Yes** ❐ **No**

If the above box is checked ***YES***, the employee is required to submit to a drug/alcohol screen which is only for the *initial* examination and emergency treatment of the injury noted above. Please conduct a drug/alcohol screen for your panel of controlled substances and alcohol, in addition to treating the occupational injury/illness. The results of the drug/alcohol screen must be reported only to the *Employer*.

____
Supervisor/Manager Name - Printed

X______________________________________ ______________________
Supervisor/Manager Signature Date

PHYSICIAN'S REPORT OF EMPLOYEE INJURY

Please be advised that this employer does not carry workers' compensation insurance. If it becomes necessary to refer to another doctor for treatment or opinion, please furnish such information to us prior to the referral for further authorization. All bills for authorized medical treatment or any inquiries concerning authorization for treatment should be directed to:

Attn: FAS, Inc.
P O BOX 2309
Addison, TX 75001-2309

Phone (866) 930-9493
Fax (972) 930-9479
EMAIL: CLAIMS@FASTPA.COM

EMPLOYER INFORMATION: ______

ADDRESS: ______ City: ______ State TX Zip: ______

PHONE: (____) ______ FAX: (____) ______ Policy# ______

Name of Injured Employee: ______

1. Date of injury: ______ Date first treatment rendered: ______
2. Description of incident: ______
3. Initial complaints: ______
4. Diagnosis: ______
5. Nature, extent, degree, body location of injury: ______
6. Treatment prescribed and prognosis: ______
7. Medication prescribed: ______
8. Probable length of hospital confinement: (if applicable) ______
9. X-rays taken ☐ Yes ☐ No If yes, results: ☐ Positive ☐ Negative ______
10. Lab test ☐ Yes ☐ No Describe procedure and results: ______
11. Was there any evidence of a prior or pre-existing injury or illness? ☐ Yes ☐ No If yes, what condition and to what extent may it contribute to incapacity or recovery? ______
12. In an effort to help employees return to work after an injury/illness more quickly, a limited duty program is available.

This Employee
- ☐ May return to work today without restrictions
- ☐ May return to work today with restrictions as indicated below for ______ days
- ☐ May not return to work until ______

13. If restrictions are required on or off the job, please indicate below:

- ☐ No standing over ___ hours
- ☐ No lifting over ___ lbs.
- ☐ No work requiring depth perception/driving
- ☐ No stooping/bending/twisting
- ☐ No reaching over shoulder height
- ☐ No walking over ___ hours
- ☐ No use R/L hand/upper extremities
- ☐ No weight-bearing R/L foot
- ☐ No climbing over ___ hours
- ☐ Must use crutches/splint
- ☐ No pushing/pulling over ___ lbs.
- ☐ No operation of machines/equipment
- ☐ Keep wound clean, dry ___ days
- ☐ No exposure to (specify, e.g. dust, chemical) ______

14a. Released to restricted duty: ______, 20____. 14b. Released to regular duty: ______, 20____

15. Will Employee require further medical treatment? ☐ Yes ☐ No If yes, date of next appointment ______, 20____
16. Comments: ______

17. SIGNATURE OF PHYSICIAN; including degrees or credentials:
(I certify that the statements apply to this bill and are made a part thereof.)

SIGNED DATE

18. PHYSICIAN'S ADDRESS, ZIP CODE & PHONE:

PIN# GRP#

MEDICAL RECORDS RELEASE AUTHORIZATION

THIS REPORT IS TO BE COMPLETED IN ITS ENTIRETY BY THE EMPLOYEE
Fax or Email this completed form to *FAS (972) 930-9479 or CLAIMS@FASTPA.COM*

EMPLOYER INFORMATION: ____

ADDRESS: ______________________________ City: ______________________ State TX Zip: ______________

PHONE: (______) ____________________ FAX: (______) ______________________ Policy# ____________________

I hereby authorize ______________________________ [name of physician, hospital or health care provider] **to furnish to Freeman Administrative Solutions, Inc., its employees, agents, and authorized representatives (hereafter individually and collectively referred to as "FAS"), any and all of my medical records and related information pertaining to my care and treatment as the result of my injury, illness, and/or claim for benefits. The medical records and related information includes, but is not limited to, medical histories, reports, charts, notes, letters, x-rays, films, MRIs, CT scans and reports, itemized bills with treatment codes, insurance and claim records, correspondence, payments, consultations, examinations, prescriptions, diagnoses, tests, and treatments.**

I understand that this information is being obtained to assist in the evaluation of my claim for benefits.

I understand that this information may be used to adjust, describe, or report matters about my care and treatment to persons entitled to receive this information.

I understand that I may revoke this authorization at any time by sending written notice to FAS except to the extent that FAS and ________________________________ **[name of physician, hospital or health care provider]** have taken action in reliance on this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to further disclosure and no longer protected by the federal health information privacy regulations. However, FAS will take precautions to maintain the confidentiality of the information disclosed pursuant to this authorization. I hereby release FAS from any liability or loss due to the release of any such information.

Nothing contained herein shall affect the treatment, payment, enrollment, or eligibility for benefits in accordance with all applicable laws.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction. A photocopy of this authorization shall have the same validity as the original.

____   ____________________________

Signed   **Date**

Name ________________________________   SSN# ____________________________

Address ______________________________   Telephone (________) ________________

________________________________   ________________________________

Representative (if applicable)   Relationship or Authority of Representative

Decline Medical Treatment Form

Fax or Email this completed form to *FAS (972) 930-9479* or *CLAIMS@FASTPA.COM*

EMPLOYER INFORMATION: ____

ADDRESS: ______________________________City: ______________________State TX Zip: ______________

PHONE: (______)____________________ FAX: (_____)______________________ Policy#____________________

I ___________________________choose to decline medical treatment that has been offered to me for an injury that was sustained on____________________. I am aware that by declining medical treatment at this time, that my employer, _____________________ will not be responsible for any medical expenses or lost wages unless specifically approved by ____________________________.

Employer

____

Employee

____

Employer Representative

____

Date