Caprock Claims Management, LLC
Texas Healthcare Foundation

Welcome to the Caprock Claims Management and THF Team

We thank you for the opportunity to join your team as the Claims Administrator for your Texas Occupational Injury Claims. We believe together we can provide the best care to protect your company's most valuable assets, your employees.

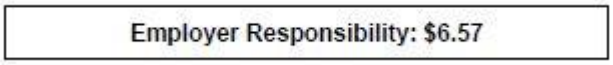
Our program includes access to a Nurse Triage Hotline where a medical professional is available 24/7 to assist your injured employee to determine the best action to take for their injury. In many cases, this eliminates the need for the employee to seek outside medical care. If the nurse determines the employee does need to see a doctor, the nurse will direct them to the appropriate urgent care or medical facility.

This service is built into the program and is of no additional cost to your company.

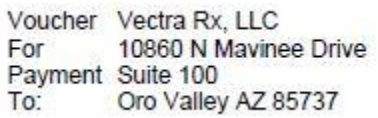
Knowing the best providers in your area to provide the appropriate care is a critical component of success in getting the required treatment. We have included a poster to be easily accessed by your staff to know where they should go for initial treatment.

When an injury is reported to our office, the prescription drug program through Vectra is activated for that individual for the specific injury. The employee will receive an identification card directly from Vectra for use anytime they are filling a prescription for their injury. There is no need for either you or the employee to pay out of pocket for the prescriptions.

All bills related to the injury should be forwarded to Caprock for processing. If Caprock is not producing checks on your behalf, then you will receive a form that is similar to a check stock. Look for the box with "Employer Responsibility". That is the amount you need to pay the provider.



The provider information is listed in the upper left of the form. See attached sample:



The following pages explain the claim reporting steps and the actions you need to take for each injury.

Please don't hesitate to contact us with any questions or clarifications

Main Phone: (972) 934-3086 Toll Free: (888) 812-3577
Fax Line: (972) 934-3091
Email Address: Info@caprockclaims.com

If you have an injury:

- ❑ **IF THE INJURY IS LIFE, LIMB OR SIGHT THREATENING, IMMEDIATELY DIAL 911**

  1. After the employee is transported to the hospital, please call (888) 812-3577 to report the injury. That way, we can coordinate with the facility, if needed.
  2. Complete Page 1 of the Employee Report of Injury form and fax to us as soon as possible.

- ❑ **ALL OTHER INJURIES**

  1. Please have the Injured Employee AND Supervisor on duty call
     NURSE TRIAGE HOTLINE 855-406-5111
     The Nurse Triage will assist the Injured Employee in determining the best action to take regarding the injury.
  2. The employee should complete the Employee Report of Injury form and sign all 3 sections of the second page even if they are not directed to an occupational clinic by Nurse Triage. This report has to be faxed or emailed to Caprock/THF using the information at the top of the form.
  3. If directed to seek medical treatment, the supervisor should complete both the top and bottom portions of the ***MEDICAL TREATMENT AUTHORIZATION*** for the Injured Employee to take to the provider and pharmacy.
  4. The Injured Employee should receive a "Work Status" form from the doctor so you are aware of any restrictions if they are returned to work, the expected time off if not released, and their next scheduled appointment. This form should then be faxed to Caprock/THF

- ❑ These additional forms may be requested by the Adjuster:
  - Supervisor's Incident Report
  - Witness Statement
  - 13 weeks' payroll preceding the injury – if lost time will exceed the disability waiting period
  - Employee's signed ERISA acknowledgement form

After the initial claim setup, we will have the responsibility to complete all other associated tasks related to a claim until it is resolved and closed. These include but are not limited to: obtaining medical and work status reports, coordinating follow up medical care and/or diagnostic or specialty referrals, receive and process claim related medical expenses, work with the employee's supervisor for light/modified duty temporary assignments, coordinating lost wage pay with HR/Payroll, and successful claim closure. Concurrent with performing these tasks, we will communicate directly with your designated contact(s) concerning claim status and expected outcome. Finally, as needed, we will handle any other regulatory reporting required.

All paperwork should be sent within 24 hours of the injury. Please contact us with any questions or concerns.

Contact Information regarding the Injury:

Main Phone: (972) 934-3086 Toll Free: (888) 812-3577
Fax Line: (972) 934-3091
Email Address: Info@caprockclaims.com

IN CASE OF LIFE, LIMB OR SIGHT EMERGENCY CALL 911

FOR ALL OTHERS PLEASE CALL:

Must be done before seeking treatment

Nurse Triage Line
(855) 406-5111

Make sure that both injured employee and authorized supervisor are present for the call.

The Nurse Triage will assist you in determining the best action to take regarding the injury. If directed to seek medical treatment, the injured employee will be sent to the nearest approved occupational clinic. They will need to take the ***Medical Treatment Authorization*** that was completed by the authorized supervisor. Please make sure the injured employee gets a Work Status form from the doctor before leaving.

Preferred Provider

	Hours of Operation
	Emergency Treatment Only

PLEASE NOTE:

If you go to a medical provider not listed above, your employer or the insurance company may not pay the bill.

AND

No referrals to specialists are authorized unless approved by Texas Healthcare Foundation.

EN CASO DE EMERGENCIA DE VIDA, MIEMBRO O VISIÓN LLAMADA 911

PARA TODOS LOS DEMÁS LLAME POR FAVOR:

Deve de ser llenado antes de obtener atension medica

Nurse Triage Line
(855) 406-5111

Asegúrese de que tanto el empleado lesionado como el supervisor autorizado están presentes para la llamada.

La enfermera lo asistira en determinar la mejor opsion respecto a su lesion de trabajo. Si es nesesario que tenga atension medica, el/la empleado (a) sera mandado a uno de los centros medico mas cercanos y aprovados por nuestro seguro. El supervisor authorizado nesesitara llenar la forma llamada ***Medical Treatment Authorization*** y el trabajador lastimado devera llevarla ala clinca. Por favor asegurese que el trabajador lastimado obtenga un Work Status (esta es la forma que especifica el estado del trabajador y si hay alguna restriction) de la clinica antes de salir.

Médico preferido

	Lunes - Viernes:
	Emergency Treatment Only

FAVOR de NOTAR:

Si usted va a un proveedor médico no listó arriba, su empleador o la compañía aseguradora no puede ser capaz de pagar su factura médica.

Y

Ningunas referencias a especialistas médica son autorizadas a menos que aprobado por la Texas Healthcare Foundation.

EMPLOYEE REPORT OF INJURY

Phone 972-934-3086 **FAX to (972) 934-3091** **Email: info@caprockclaims.com**

A complete First Notice of Loss must be submitted immediately

We also need a copy of your signature page from the Summary Plan Description and Arbitration Agreement

Please print

Employer Information

Group Name | Group Policy Number

Supervisor/Manager Name | Supervisor/Manager Phone Number

Employee Information

Injured Employee Name | Soc. Sec. Num. | Date of Birth

Home Address *(incl. city, state, zip)*

Home Phone Number | E-mail Address

Employment Status | Job Title/Description

☐ Active ☐ Disabled ☐ Terminated

Date Hired | Date Last Worked | Date Disability Began

EMPLOYEE'S STATEMENT OF INJURY

Date of Accident | What time did the accident happen? (Specify am or pm) | Date of Report

When was the accident reported to Supervisor? | Name of Supervisor in charge at the time

What was the CAUSE of the accident?

WHERE did the accident occur?
(PHYSICAL ADDRESS)

What BODY PART(s) were injured?

What Type of Injury (ex.: Cut, Sprain, Fracture…)

Describe the DETAILS of the accident and how it happened. *Attach additional paper if necessary.*

Did the injury require immediate emergency treatment? Yes☐ No☐

WAS OFFERED MEDICAL ATTENTION AND/OR TREATMENT BUT EMPLOYEE REFUSED

EMPLOYEE SIGNATURE

Date of 1st Medical Treatment

Treating physician and treating facility (name, address and phone number)

Have you ever been treated for this before? If yes, please explain.

Give full name, address and phone number of ALL other physicians consulted in the past three years.

EMPLOYEE NAME (PRINT) **DATE OF INJURY**

ACKNOWLEDGMENT

I ACKNOWLEDGE THAT MY EMPLOYER HAS A MANDATORY ARBITRATION AGREEMENT OR POLICY IN PLACE AT THIS TIME THAT COVERS MY INJURY CLAIM THAT I HAVE REPORTED AS OF THE DATE SHOWN BELOW. THAT AGREEMENT OR POLICY COVERS ANY CLAIMS I HAVE AGAINST MY EMPLOYER, ITS EMPLOYEES, AGENTS, OWNERS, PARENT ENTITIES, SUBSIDIARIES, DIVISIONS OR OTHER AFFILIATED OR RELATED INDIVIDUALS OR ENTITIES ARISING FROM ANY INJURY I INCUR IN THE COURSE AND SCOPE OF MY EMPLOYMENT (EXCEPT BENEFIT CLAIMS UNDER THE EMPLOYER'S BENEFIT PLAN AND CERTAIN CLAIMS THAT ARE NOT ARBITRABLE) AND PROVIDES THAT THOSE CLAIMS SHALL BE EXCLUSIVELY RESOLVED IN A BINDING ARBITRATION ADMINISTERED BY JUDICIAL WORKPLACE ARBITRATIONS. TO THE EXTENT I HAVE NOT BEEN PREVIOUSLY NOTIFIED OF THIS AGREEMENT OF POLICY, I UNDERSTAND AND AGREE THAT CONTINUING TO WORK FOR EMPLOYER AFTER RECEIVING THIS NOTICE OR ACCEPTING ANY BENEFITS UNDER MY EMPLOYER'S BENEFIT PLAN FOR INJURIES IN THE COURSE AND SCOPE OF MY EMPLOYMENT CONSTITUTES IRREVOCABLE ACCEPTANCE OF MY EMPLOYER'S ARBITRATION AGREEMENT OR POLICY.

EMPLOYEE SIGNATURE DATE

Right of Subrogation and Refund

The injured employee may incur expenses due to injuries for which benefits are paid by the Injury Benefit Plan. If the injuries are caused by the wrongful act, omission or negligence of another person, the employee may have a claim against that other person for payment of the expenses. The Plan will be subrogated to all rights the employee may have against that other person and the employee must repay us out of the recovery made from: (a) the other person; or (b) the other person's insurer; or (c) any carrier providing uninsured or underinsured motorist coverage. The employee agrees to assist us in any recoveries and to not take any action that would prejudice our subrogation rights. The subrogation rights only apply to the amount of the Injury Benefit Plan paid because of that injury or death.
Name and address of third party or other party involved:

EMPLOYEE SIGNATURE DATE

Authorization for Release of Medical Records

I certify that the information is true and correct to the best of my knowledge. I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, or other organization, institution or person that has any records or knowledge of me or my health to give to my Occupational Injury Benefit Plan Administrator, Caprock Claims Management, their legal representative, or designees any such information. Such release may include information that may be considered a communicable and/or venereal disease, hepatitis, HIV related, AIDS, AIDS related disorders, mental/nervous disorders, drug abuse and/or alcoholism. I understand the information obtained using this Authorization will be used by my Occupational Injury Benefit Plan Administrator or Caprock Claims Management to determine eligibility for benefits under the Group Policy. Any Information will not be released to any person or organization except insurance companies, or any other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

A photocopy of this Authorization shall be as valid as the original.

I understand that I am entitled to a copy of this Authorization.

EMPLOYEE SIGNATURE DATE

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

MEDICAL TREATMENT AUTHORIZATION

Give this to the injured employee to show the doctor & pharmacist. Send a copy to us.
Email to Caprock/THF at info@caprockclaims.com or fax to (972) 934-3091.

Employee Name: _____ Date of Injury: _____

Employee SS#: _____ DOB: _____

Policyholder name: _____ Policy Number: _____

Description of Injury for treatment: _____

_____

Drug/Alcohol Screen Required: ❒ Yes ❒ No
Please conduct a drug/alcohol screen for your panel of controlled substances and alcohol, in addition to treating the reported work-injury. The results of the drug/alcohol screen must be reported only to the Employer and/or Caprock/THF.

Dear **Medical Provider**:

This injured worker is covered under an Occupational Accident Policy administered by Caprock Claims Management. The employer is committed to providing modified duty within the restrictions you define. **A work status form with any restrictions and the next scheduled appointment is required.**

Please contact **Caprock Claims Management** to verify coverage and pre-certify services:
Call (972) 934-3086 or (888) 812-3577
Fax (972) 934-3091

Dear **Pharmacy Provider**:

The Caprock Claimant attempting to use your pharmacy has not received their permanent prescription drug card yet. In order to avoid any delays in service, the member has been provided with this letter containing the information needed to adjudicate their claim through **OccuScript**. This program is valid only for prescribed medications that are directly related to the occupational injury. If the claimant has questions they can contact the Claimant Help Desk (800) 925-9777.

Member ID: **100** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
M M D D Y Y — Date of Injury
SSN

Group Number: **VRX001**	BIN Number: **600471**	PCN Number: **7777**

For the 9 digit ID, use the injured worker's SSN. If the injured worker does not want to use their SSN, they can call the Claimant Help Desk (800) 925-9777 and the Help Desk will assign the injured worker a unique ID number.

Attention Pharmacists: OccuScript is an online pharmacy benefits program administered by OptumRx. If you have questions or processing problems, call our pharmacy help desk at (888) 554-8471, 24/7.

TEXAS HEALTHCARE FOUNDATION
ON BEHALF OF: 5526 Washington LP
1825 Lakeway Drive, Suite #200
LEWISVILLE, TX 75057
(972) 317-1252

Check Date: **7/9/2018**
CLAIMANT: Doe, John
Policy Number: TNS0002222

Pinnacle Bank
87-0863 / 0640

No: 3004984

Six Dollars And 57/100 ******** ********** $6.57**

Voucher For Payment To: Vectra Rx, LLC
10860 N Mavinee Drive
Suite 100
Oro Valley AZ 85737

NON-NEGOTIABLE VOUCHER

Provider Bill Detail

Payer: CPro Associates **Check Number:** 3004984 **Check Date:** 7/9/2018

Claim Number: 0000300001710
Claimant Name: Doe, John
SSN: XXX-XX-1111
Date of Birth: 06/10/1996
State of Jurisdiction: Texas
ICD9 Codes:

Date Received: 06/25/2018
Date Reviewed: 06/29/2018
Date of Injury: 04/06/2018
Document Number: 3131005
Invoice Number:
Employer: ABC Sample Company

Examiner: vmattson
Bill Type:
Pay Code: 5230
From: 04/06/2018
Through: 04/06/2018

Date	Code	Mod	Description	Qty	Billed	PPO	Other	Savings	Allowed	Reason
4/6/2018	00093314705		CEPHALEXIN (USP) 500 MG	0.00	$39.44	$0.00	$0.00	$0.00	$39.44	
			Totals:		**$39.44**	**$0.00**	**$0.00**	**$0.00**	**$39.44**	

Employer Responsibility: $6.57

To Be Paid by Carrier: $32.87

***** If you have any questions concerning this payment, please contact our claims processing center at: *****
Texas Healthcare Foundation / Occusystems
1825 Lakeway Drive • Suite 200 • Lewisville, Tx 75057 • Phone: 972-317-1252 • Fax: 972-317-0889