CALM Worker's Compensation Claim Kit

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AmTrust INSURANCE

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AmTrust FINANCIAL

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AmTrust FINANCIAL

24/7 Toll Free Claim Reporting for All States

1-(844) 614-9181

Press 1 to speak with AmCares® Nurse Triage

Press 2 to report a claim if treatment already occurred

CALM@amtrustgroup.com

AmTrust also accepts emailed PDF of the First Report of Injury, submitted to

CALM@amtrustgroup.com

For best claim outcomes when an injury occurs, call AmCares®, where one phone call addresses nurse triage and reports the claim. The AmCares® nurse will tale care of triaging the injury, directing to in network care and reporting the claim to AmTrust. Utilization of AmCares® generally leads to an increase in injured employees' satisfaction, network utilization, and possibly a reduction in medical cost, lost time from work, and unnecessary emergency room visits.

AmCares®

AmCares® is a 24/7 nurse line available to injured employees where nurses use nationally recognized triage guidelines to identify the appropriate level of care for an injured employee's injury: Self-care, Telemedicine, Occupational Clinic, Urgent Care, or Emergency Room. If the injury is self-care, it will be entered as a report only claim. Nurses speak both English and Spanish, other languages available as needed.

Information Required for All Claims Reported

1. Provide the policy # and name of college
2. Name and contact information of injured employee
3. Date, time and place of accident
4. Description of accident or incident
5. Name, phone, and/or email of a person making the report
6. Any information on the injured workers lost time

Early claim reporting is essential to a better claim outcome. Don't delay reporting if you do not have all the details!

If theAmCares line was utilized, the claim filing has been completed for you. If the AmCares line was NOT utilized claim filing is mandatory, email a PDF of the **First Report of Injury** to CALM@amtrustgroup.com

How do I help my injured employee find a doctor?

- Report your claim via AmCares® and the nurse will find the doctor!
- If not using AmCares®, we offer an online physician search, www.talispoint.com/amtrust/external

How does my injured employee receive prescription medications related to the accident/injury?

- Refer to your claims kit at Customer Payment and Claim Center - CALM for a First Fill card for your injured employee to use at the pharmacy to cover the cost of approved medication.

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CALM & AmTrust Claim Reporting Best Practices

Timely Reporting

- Please file claims with AmTrust as soon as possible after being notified of an injury by your injured employee, preferably the same day. If the AmCares line was utilized, the claim filing has been completed for you. If the AmCares line was NOT utilized claim filing is mandatory, email a PDF of the First Report of Injury to CALM@amtrustgroup.com.
- Early claim reporting is essential to a better claim outcome. Don't delay reporting if you do not have all the details!

Directing Care

- State law requires medical treatment to be offered within 5 days of the notice of injury to retain employer choice of treating physician. If treatment not offered within 5 days of notice of injury, the employee can choose the treating physician. Directing an injured employee to an AmTrust network physician is critical to ensure timely, quality treatment and a medically appropriate return to work.
- Utilize AmCares to direct injured employees to an AmTrust network provider or use our online physician search, www.talispoint.com/amtrust/external
- Report Only claims, where an incident occurs but no medical treatment is needed, should be reported as "RO" claims, and will not count as a claim on your loss history or count towards your premium calculation. If the employee refuses medical treatment, have them sign a statement that they refused treatment and send it to AmTrust.

Claim Documentation & Medical Bills - Include Claim number on all correspondence.

- Amtrustclaims@amtrustgroup.com is the most efficient manner to share correspondence related to the workers compensation claim. This includes but is not limited to wage information, witness statements and work status reports.
- Wage information is gross salary for 52 weeks prior to the date of injury. If there are not 52 weeks available, gross wages should be supplied from date of hire to the day prior to the date of injury.
- Employees should be advised that any bills related to their on-the-job injury received at their home can be emailed to Amtrustclaims@amtrustgroup.com, or brought to you for forwarding to: AmTrust North America, P.O. Box 89404, Cleveland, OH 44101.

Forms

- **Medical Care Authorization Form.** This form is used when the injured employee needs initial medical treatment away from the work site. Print the form, complete the top section and send it with the injured employee to the medical provider
- **Witness/Co-Worker Statement.** This form is completed by the person that witnessed the injury.
- **Consent Authorization for Disclosure of Protected Health Information.** This is required for AmTrust to obtain medical records. **Must be signed by the Injured Employee**
- **Report of Occupational Injury or Illness Forms.** To be completed by the employee and the supervisor/manager on the day the injury occurs. If the injury results in the need for immediate medical attention, please have the employee complete this form when physically capable and then forward to AmTrust. **Must be signed by the Injured Employee**

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CALM & AmTrust Claim Reporting Best Practices

Communication

- The Claims adjuster will contact you and the injured employee to discuss the claim. Make sure the employee knows the adjuster will be contacting them and strongly encourage them to take the time to discuss the claim with the adjuster thoroughly. Give the adjuster the injured employee's cell phone number if that is their preferred method of communication.
- Keep in close contact with your injured employee regarding their treatment and off-work status. If they have questions that you cannot answer, please refer them to their assigned adjuster.
- Notify the adjuster if your injured employee misses work due to their doctor's orders, as well as when the employee returns to work.

Posting Notice Requirements

CC-Form-1A Oklahoma Workers' Compensation Notice & Instruction to Employers & Employees

- Post at place of employment, in a sufficient number of places on the premises to assure that the notice will reasonably be seen by all employees.
- Employees that may not reasonably be expected to see a posted notice must receive notice of the posting in writing.
- The notice(s) shall contain the name and address of the carrier, as well as the expiration date.
- To complete the form, please enter the name of your designated insurance carrier, your policy expiration date as well as a signature of a company representative. For your convenience, our contact information has been completed on the poster.
- (Oklahoma Statutes § 85-43(D))

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AmCares

AmCares Nurse Triage Reference Guide

Information
TO REPORT A WORK-RELATED INJURY OR ILLNESS CALL
24 HOURS PER DAY/365 DAYS PER YEAR

Instructions
If an employee has sustained a work-related injury that is not life, limb or eyesight threatening call the AmCares Nurse Triage service and speak with a nurse at:

1-844-614-9181

INSTRUCTIONS FOR MANAGER REGARDING PROCESS WITH THE NURSE:

- Provide a private and secure area for the employee to speak with the nurse.
- Inform the nurse of any language needs; bilingual nurses are available; Spanish and English. For other languages, the nurse will bring in an interpreter prior to speaking with the employee.
- The nurse will ask questions to rule out an emergent situation. If the nurse does assess a life, limb or eyesight threatening situation, they may request assistance in getting Emergency Medical Services.
- The nurse will complete an assessment and derive at a medical care or self-care disposition.
- The nurse will ask the employee to place the manager back on the phone if they are available. The nurse will communicate the instructions that were given to the employee.

AFTER THE EMPLOYEE SPEAKS WITH THE NURSE:

Once the employee has completed their call:

- The manager will assist per company policy to ensure that the employee is able to follow the nurse's recommendation
- The manager will complete any internal reporting required per company policy

TO GET A PRESCRIPTION FILLED:

If an employee needs to go for medical care, the nurse can offer to provide the phone number to the employee. Employee will have to provide the pharmacy with the below:
Optum - RX Bin – 004261; RXPCN – CAL; Group FF; Help Desk: 866-599-5426

CLAIM AND MEDICAL BILLING INFORMATION:

- Send all bills to **P.O. Box 89404, Cleveland, OH, 44101**
- For Claim Questions call **1-888-239-3909**

Employer's First Report of Injury Form (FROI)

Submit Form to: AmTrust North America
Email: CALM@amtrustgroup.com

Employee Information

Full Name of Employee- Last, First, Middle	*SSN - Last 5 digits*	Date of Birth	Sex

Complete Mailing Address (include, city, state, zip code)	Employee Email Address

Home Telephone Number	Work Telephone Number	Mobile Telephone Number

Occupation/Job Title	Job Description	NCCI Class Code	Length of Employment: Years: Months: Date of Hire:

Organization/Location	Department/Division	Average Weekly Wage

Employer/Insurance Information

Employer Name	Federal Tax ID#	Telephone Number

Address	City	State	Zip	Type of Ownership: Private ☐ State Gov't ☐ County Gov't ☐ Local Gov't ☐

Type of Business (Example: manufacturing, food service, construction)	NAICS Number

Employer's Insurance Carrier/Own Risk Group	Policy/Self-Insured Number	Policy Period
AmTrust North America		7/1/25 – 6/30/26

Address	City	State	Zip	Telephone Number
PO Box 89404	Cleveland	OH	44101	

Injury Details

Date of accident/last exposure	Time of accident/last exposure	Time workday began

Injury Resulted from: Single Incident ☐ Cumulative Trauma ☐ Occupational Disease ☐	Did the employee die? If yes, on what date?

Date Employer notified	Place of Accident/Occurrence City County State Zip Code	Does employee participate in a certified workplace medical plan: If yes, name of CWMP:

Last Date employee worked	Has employee returned to work? If yes, on what date?	OSHA Recordable? If so Log Case Number:

Nature of Injury/Illness

Identify part(s) of body involved in injury/illness

Describe activities when injury occurred with details on how event occurred. Include object or substance which directly injured the employee.

Full Name and address of treating physician (please be complete)

Additional Information/Comments:

Signature of Preparer: _____ Date:_____

Name and Title of Preparer (Please Print): _____

OPTUM®

AmTrust North America
An AmTrust Financial Company

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

AmTrust North America
An AmTrust Financial Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
CARRIER/TPA

EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER

DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-109-FFWG

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
PORTADORA — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL — FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-109-FFWG

Employer's Workers' Compensation Policy Information and Initial Authorization*

General information related to your employer's workers' compensation policy:

- **Employer name (insured):** _____
- **Employer address & phone #:** _____
- **Insurance company name:** _____
- **Policy number:** _____

If you experience a work-related injury, it is beneficial to provide the following information to a provider:

- **Employee name:** _____
- **Date of injury:** _____
- **Body part:** _____
- **Claim number (if available):** _____
  - Be advised: claim number & adjuster information may not be available if injury just occurred. Facility should allow time for claim to be established by AmTrust North America, Inc. and call next business day if needed at 888-239-3909.

Insurer Billing Information

AmTrust North America, Inc.
P.O. Box 89404
Cleveland OH 44101
Fax: (678) 258-8395
Email: AmTrustClaims@amtrustgroup.com

AmTrust Contact Information

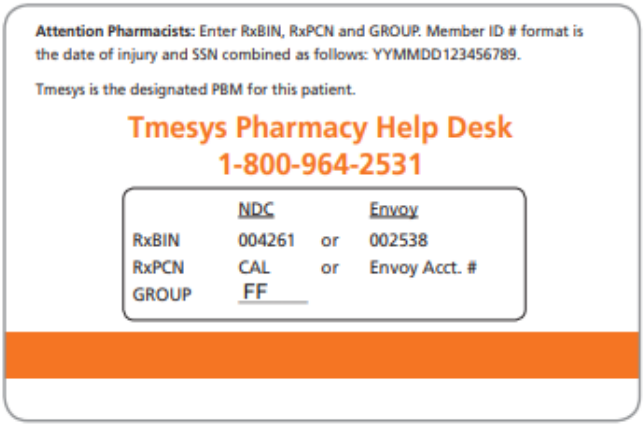
Tel: 888-239-3909

Provider Directory

Physician and facility search available at
www.talispoint.com/amtrust/external/

California provider directory
www.talispoint.com/amtrust/campn/

Pharmacy Information



*An injury report by an employee is not an official written notice of a claim for workers' compensation benefits. Please note that this document does not certify compensability, ensure coverage, or guarantee payment of a claim or medical bill.

STATEMENT OF WAGES/SALARY

IMPORTANT: PLEASE COMPLETE ALL INFORMATION REQUESTED

Employee: Employer: Claim Number:
Social Security Number: Date of Hire: Position/Job Title

EMPLOYMENT TYPE: Full Time ☐ Part Time ☐ Seasonal ☐ Temp ☐
If Temporary or Seasonal worker, last day of season or job end date _____
WAGE TYPE: Hourly ☐ Salary ☐ Commission ☐
WAGE INFORMATION:
$_____ per hour ; Monthly Wage $_____ ; Does monthly wage include commission ☐ Yes ☐ No
Hours per Week _____ ; Overtime Rate $_____ per hour ; Overtime Hours Regularly Worked per week ____
Tips reported: $_____ per week

If employees' compensation package includes an allowance for any of the following, please indicate the actual or estimated value:
Meals: $_____ per week Auto: $_____ Rent/Lodging: $_____ per week Bonus $_____ per ☐ wk ☐ mth ☐ yr

PLEASE COMPLETE THE BELOW FOR THE PERIOD _____ TO _____

WK	Pay Rate	Hrs Worked	Begin Date	End Date	Gross Salary	WK	Pay Rate	Hrs Worked	Begin Date	End Date	Gross Salary
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
15						41					
16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					

AmTrust North America
An AmTrust Financial Company

Authorization for Release of Medical Information

Provide Signed Form to:
Amtrust North America | AmTrustClaims@amtrustgroup.com |Fax: 678-258-8579

Patient Name _____ DOB: _____
Patient Address: _____
Claim Number: _____

I hereby authorize the use or disclosure of my individually identifiable health/medical information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations.
I authorize the release of information from all medical sources, including: hospitals, clinics, labs, physicians, psychologists, psychiatrists, mental health care providers or facilities, correctional facilities, additional treatment providers or facilities, VA health care facilities, school doctors, nurses and counselors, records administrators, social workers, social security administrators, rehab consultants or counselors, managed care consultants or counselors, vocational consultants or counselors, employers and other insurance carriers and/or their representatives.

Information to be released: **Entire Record**

I understand that my records may contain reference to or results of HIV (AIDS) testing, testing or treatment of communicable diseases, treatment for mental health problems, alcohol history or substance abuse, and I authorize the release of such information to the indicated party, unless specifically prohibited in my instructions above.

Purpose of Disclosure: **At the Request of the individual or his/her legal representative**

I understand that my health care provider shall not condition my treatment, payment, enrollment in health plan or eligibility for benefits on whether I provide authorization for a requested disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.
I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to AmTrust North America representative identified above. I understand that a revocation is not effective to the extent that action has already been taken in reliance on the authorization.
I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

Expiration Date: This authorization to disclose this protected health information is valid until the final resolution of the insurance claim in relation to which this authorization is granted or for 24 months from the date of signature, whichever comes first, at which time this authorization will expire.

I understand that a photocopy of this authorization shall have the same force and effect as the original document.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Legal Representative's Authority or Relationship to Patient Daytime Phone | Patient / Representative

WITNESS/CO-WORKERS STATEMENT

I, _____ was present at the time that employee

_____was reported to have received an on-the-job injury.

I did_____ did not_____ witness the injury that occurred.

The following is a brief description of what I observed on _____ at approximately_____ a.m./p.m.

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, that they are correct and complete.

_____

Witness Date

_____

Employer

Send Original To:
AmTrust Insurance
P.O. Box 89404
Cleveland, OH, 44101,
Amtrustclaims@amtrustgroup.com

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Occupational Injury or Illness **Supervisor** Report

The accident should be investigated by the supervisor of the injured employee or department involved. It should be completed soon as possible to obtain the most accurate information.

Date of Injury:	Date Reported:	Employer Name:
Name of Employee:	Occupational Title:	
Time Work Shift Began: AM/PM	Time Accident Occurred: AM/PM	Day of week M T W TH F S SU
Location:		

Injury Type (Circle)

Foreign Body in Eye	Animal, Insect, Human Bite	Fracture	Burn (Chem, Liquid, Electrical)
Cut/Puncture	Hernia/ Rupture	Amputation	Exposure (Blood/ Body Fluid)
Abrasion/Scratches	Heart Attack/Stroke	Sprain/Strain	Skin Irritation/ Dermatitis
Bruise/Contusion/Crushing	Hearing Impairment	Death	Other
Concussion/ Loss of	Exposure (Chem. Temp. Elect)		

Injury Cause (Circle)

Struck by/ Against Object	Caught in/Under/ Between	Jumping or Climbing	Animal, Insect, Human
Fall-Same Level, Different Level	Pushing/Pulling/ Lifting/ Carrying	Noise	Repetitive Motion/Trauma
Hot Object, Substance or Fire	Vehicle Accident/ Struck by Vehicle	Slipping/Tripping	Other

Was injury caused by another person, faulty/broken equipment, a vehicle?	Yes	No	

If yes, explain:

Body Part Injured (Circle)

Head/Neck/Face/Mouth	Wrist L / R	Hips/ Buttocks	Arm L / R	Elbow L / R
Eye L / R	Hand L / R	Fingers L / R Digit:	Pelvis/ Groin	Shoulder L / R
Ear L / R	Back (Upper Lower)	Knee L / R	Ankle L / R	Foot L / R
Leg (Thigh Calf)	Toes L / R Digit:	Respiratory	Other	No Physical Injury

Chest/Abdomen Including internal organs

First Aid or Medical Treatment

Was first aid given?	Yes	No	If yes, by whom:

Was medical treatment required by a physician or hospital?	Yes	No	Physician/ Hosp Name, Address, and telephone number:

As a result of your investigation, what do you believe occurred and why?

From your investigation is the validity of the accident in doubt?	Yes	No	If yes, explain why.

Was a third party at fault? If yes, explain

Were there any witnesses? If yes, please list and have witness complete attached form

Name	**Address**	**Phone**	**Date**

Supervisor's Signature:	**Date:**

Occupational Injury or Illness **Employee** Report

It should be completed soon as possible to obtain the most accurate information.

Employee Name:	Employer:
Explanation of injury (How, When, Where)	

Date you first noticed the pain?	Did this pain develop gradually?	Or suddenly?

If the pain developed suddenly, exactly what were you doing when the pain was felt?

If nothing unusual or unexpected happened, what do you think caused the pain?

List body parts injured:

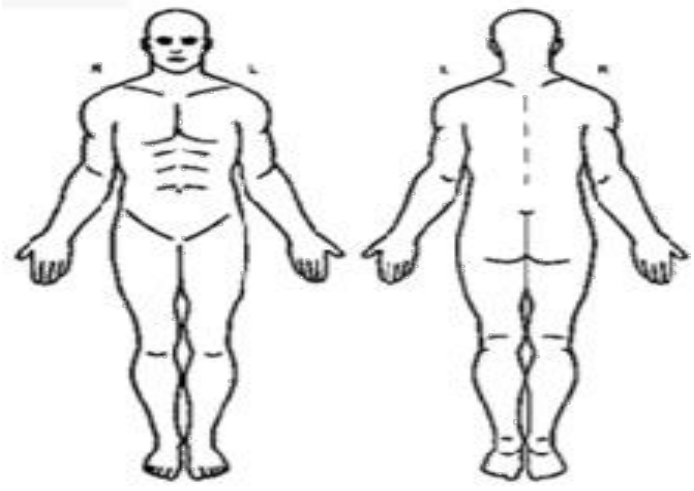
Have you discussed this pain with anyone at work? If yes, with whom and when? Yes No

Have you had any recent non-work-related injuries/illnesses? If yes, please list: Yes No

If the above answer is yes, what was the problem, when did it occur, and what (if any) medical treatment did you receive?

Show part(s) of the body injured, noting the longevity, type and degree of pain.

On the diagram below, indicate the location, description, and level of pain you are experiencing at this time.
Example: **"A-6= Ache- Severe pain"**



Note type of pain:

A = Ache	**B** =Burning	**P** = Pins & Needles
N = Numbness	**S** = Stabbing	**O** = Other

Note level of pain:

0	No Pain
1	Mild pain, you are aware of it, but it doesn't bother
2	Moderate pain that requires medication to tolerate the
3	More severe pain
4	Severe pain
5	Intensely severe pain
6	Most severe pain, unbearable

Was medical treatment away from the job site offered?

Yes No

If treatment was offered, but declined, please sign:

Have you ever received medical treatment for the injured body part(s) listed above? If so, please note the date and physician/hospital where treatment was rendered.	Yes	No	

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief they are correct and complete.

Employee Name (Print): **Date of Birth:**

Employee Signature: **Date:**