Sedgwick ClaimsManagement Services, Inc.
Clinical Consultation Referral Services

The injured worker listed on the accompanying report has been referred/chosen you for treatment. Sedgwick is the TPA for Workers' Compensation claims.

This does not guarantee that benefits will be payable under Workers Compensation coverage. Benefit payments are always subject to a determination by the claim's examiner at the time the service was rendered.

Submit medical invoices to Sedgwick at: PO Box 14155, Lexington, KY, 40512-4155

- For claim/bill/payment inquiries: Providers can access viaOne® for Providers at https://Sedgwick.com. Click on "Your Claim" then "Check a Claim", next click "Providers section", then "viaOne Provider. For questions regarding submitted bills: Ph: (866) 495-7844.

- All inquiries about ebilling to Sedgwick can be directed to the dedicated website https://datadimensions.com/sedgwick/

- Prescriptions written during the initial visit should be directed to a pharmacy from the accompanying Pharmacy form, Optum: (800) 229-4377

- **Discount Tire** has a transitional return-to-work program available for the injured employee. All injuries will be considered for modified work duties. Please perform a physical capabilities evaluation as part of your examination and give it to the Employee to return to their Supervisor.

- Fax treatment requests to the Sedgwick Utilization Review Unit: **FAX (877) 922-7236, Ph: (866) 286-0281**

- **For all Sedgwick Specialty Services, contact Provider Connection: 1-87-SEDGWICK (1-877-334-9425).**

  - Physical Therapy
  - Durable Medical Equipment
  - Diagnostics
  - Transportation
  - Translation
  - Dental

Standard: Disclosures for workers' compensation. A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault. 45 C.F.R. § 164.512

Physical Capacities Evaluation

Patient's Name:	**Job Title:**	
Diagnosis:	**Date of Service:**	**Time In:**
		Time Out:

Doctor: *This form will be used to make some determinations regarding your patient's ability to perform work-related activities. Please complete the following items based upon your clinical evaluation, the objective medical evidence and diagnostic test results.* ***Please provide this form to employee to return to employer.***

In a typical 8-hour day, the patient can (check full capacity for each activity, numbers indicate hours):

(PLEASE CHECK # OF HOURS, i.e., 1, 2, 3, etc)

Activity	0	1	2	3	4	5	6	7	8	9	10	11	Special Instructions
Sit:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Stand:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Walk:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Drive Vehicles (Bus/Utility):	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Operate Machinery (Rail):	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Total hours patient can work	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

The patient can perform these physical demands (please check all that applies)

	Never 0 hours	Rarely 1-3 hours	Occasionally 3-6 hours	Frequently 6-8 hours	Continuously 8+ hours
☐ Lift___lbs (indicate maximum # of lbs)	☐	☐	☐	☐	☐
☐ Climb stairs	☐	☐	☐	☐	☐
☐ Climb ladders	☐	☐	☐	☐	☐
☐ Bend	☐	☐	☐	☐	☐
☐ Kneel	☐	☐	☐	☐	☐
☐ Squat	☐	☐	☐	☐	☐
☐ Crawl	☐	☐	☐	☐	☐
☐ Flex or extend neck	☐	☐	☐	☐	☐
☐ Simple grasping	☐	☐	☐	☐	☐
☐ Fine Manipulation	☐	☐	☐	☐	☐
☐ Keyboarding	☐	☐	☐	☐	☐
☐ Can return to full duty – no restrictions	☐	☐	☐	☐	☐

These restrictions are TEMPORARY and will be reassessed on: _____ *MM/ DD/ YYYY*	Patient is able to return to full duty within 180 days: ☐ Yes ☐ No
Treatment Facility (please check): ☐ Occ Med ☐ Emergency Room ☐ Urgent Care	Was patient referred to a specialist? ☐ Yes ☐ No Next office visit date: _____ *MM/ DD/ YYY*

Print Doctor's Name:	**Doctor's Signature**
Telephone Number:	*I understand that by signing this form, I am agreeing to furnish a copy to my work location* **Employee's Signature:**

Optum sedgwick

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 person:

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

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

Find a network pharmacy

Most pharmacies 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

Employer:

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

Optum sedgwick

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Sedgwick	Discount Tire
CARRIER/TPA	**EMPLOYER**

INJURED PERSON 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: **Call 1-800-964-2531 to establish First Fill benefit eligibility and to obtain the ID# for online adjudication of approved benefits for the injured individual. 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.#

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

tmesys®

IMP-22-361

Hacemos más sencillo que se le abastezca las recetas de su 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 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.

Persona lesionada:

Si necesita que se le abastezca su receta médica para una lesión relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. En la mayoría de los casos, la farmacia abastecerá la receta sin costo para usted.

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 relacionadas con su trabajo.

Cómo encontrar una farmacia de la red

La mayoría de farmacias y todas las grandes cadenas de farmacias forman parte de la red. Para ubicar una farmacia de la red, llame al 1-866-599-5426 **o visite** tmesys.com**.**

¿Tiene alguna pregunta? ¿Necesita ayuda?

1-866-599-5426

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información que aparece a continuación y entregue este formulario al empleado.

Optum sedgwick

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Sedgwick	Discount Tire
PORTADORA	**EMPLEADOR**

NOMBRE DEL PERSONA LESIONADA

Please provide directly to Pharmacist

NUMERO DE SEGURO SOCIAL **FECHA DE LA 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: **Call 1-800-964-2531 to establish First Fill benefit eligibility and to obtain the ID# for online adjudication of approved benefits for the injured individual. 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.#

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

tmesys®

IMP-22-361

Workplace Injury Triage & Reporting
Confidential: Incident Report

Call Reference Nbr **26768312** | Initial Call Reference Nbr

Company Location

Company Name & Address	Location Name & Address / Off-Premises Address	Special Client Information
Reinalt-Thomas Corporation **20225 N Scottsdale Rd** **Scottsdale, AZ 85255**	**Discount Tire - TRH001 / 7101 Vorden Parkway** **7101 Vorden Pkwy** **South Bend, IN 46628**	

Location Phone	Location Fax	Client Incident Nbr

Caller

Name	Title	Callback Phone
Nicolas Lopez Anderson	**Employee**	**574-287-2345**

Additional Caller Info

Was employee present during call? **Yes**

Employee Demographics

Last Name **Lopez-anderson**
First Name **Nicolas**
Middle Initial **Aaron**

Home Address
2088 E Empire Ave, Lot 135
Benton Harbor, MI 49022

Home Phone
Mobile Phone **574-274-7074**
Email **nicolaslopezanderson@gmail.cc**

Date of Birth **12/26/1996**
SSN / SIN **xxx-xx-9777**
Marital Status **Single**
Dependents **0**
Sex **M**

Employment

Employee ID **27084**
Occupation
Division
Base Location
Department
Supervisor **Nick Pugh**

Date of Hire **12/13/2022**
Status **Full Time**
Shift

Incident Report

Triage Agent **01022133**

Incident Date	Call Date	Date Rpt'd to Mgmt	Shift Start Time	Incident Location
5/24/2023	**5/24/2023**	**05/24/2023**	**08:00**	
Incident Time **13:30 ET**	Call Time **12:29 CST**			

Injury & Recommended Action

Nature of Injury - Body Part
Eye - Right

Impression(s) Eye Symptoms

Mechanism of Injury	**Foreign Body To Eye**
RN Recommendation	**Referred Emergent**
Employee Decision	**Referred Emergent**
Employee Decision Definition	**Referral within 2 hours to medical provider**
Recommended Action	**No Additional Action Required**

Referral

Referred **YES**
If referred, was the provider in client's designated network? **YES**
If no, why?

Primary Provider Name & Address
Beacon Occupational Health LLC
2301 N Bendix Dr Ste 500
South Bend, IN 46628

Provider Phone **574-647-1675** | Provider Fax **574-232-5595**

Secondary Provider Name & Address

Provider Phone | Provider Fax

Date and Time Report Printed: **05/24/2023 12:51**

Workplace Injury Triage & Reporting
Confidential: Incident Report

Call Reference Nbr	26768312	Initial Call Reference Nbr

Witness to Incident

Witness 1 Name	Phone	Witness 2 Name	Phone

Other Incident-Related Questions

Additional Information (If Applicable)

Workplace Injury Triage & Reporting
Confidential: Incident Report

Call Reference Nbr	26768312	Initial Call Reference Nbr

Call Notes

[Note Entered: 05/24/2023 12:33 CT; Ref Nbr: 26768312]
Initial Scenario. EE calling per direction of HR. EE alleges approximately 20 minutes ago while cutting shrink wrap off of a skid, he was using an ink pen and the ink cartridge part flew out hitting him in the right eye. EE reports seeing halos around light. EE referred to provider d/t seeing halos around light. Call closed with HR, Bianca.

INSTRUCTIONS

General Instructions:

1. Please enter information into all of the areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.

2. Enter all dates in MM/DD/YY format.

3. Please return completed form electronically by an approved EDI process.

4. For answers to questions, please call (317) 232-3808.

Definitions:

AGENT NAME AND CODE NUMBER: Enter the name of your insurance agent and his / her code number if known. This information can be found on your insurance policy.

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED: List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and / or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (*e.g. Acetylene cutting torch, metal plate, etc.*).

AVG WG/WK: Claimant's average weekly wage, calculated by totaling the latest 52 weeks of wages (*including overtime, tips, etc.*) and dividing by 52.

CLAIMS ADMINISTRATOR: Enter the name of the carrier, third-party administrator, state fund, or self-insured responsible for administering the claim.

CONTACT NAME / TELEPHONE NUMBER: Enter the name of the individual at the employer's premises to be contacted for additional information (*i.e. Supervisor, HR Person, Nurse, etc.*)

DATE DISABILITY BEGAN: The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwised deigned by statute.

DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED: If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (*e.g. Maintenance, Client's Office, Cafeteria, etc.*).

EMPLOYEE STATUS: Indicate the employee's work status from the following choices: Full-time, Part-time, Apprentice Full-time, Apprentice Part-time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as: (*FT, PT, AFT, APT, VO, SW, PW, OS, DI, RE, NE, or UK*).

HOW INJURY / ILLNESS OCCURRED: Describe the sequence of events leading to the injury or exposure (*e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall*).

NCCI CLASS CODE: A four-digit code classifying the occupation of the claimant.

OCCUPATION / JOB TITLE: Enter the primary occupation of the claimant at the time of the accident or exposure.

PART OF BODY AFFECTED: Indicate the part of body affected by the injury / illness (*e.g. Right forearm, Low Back, etc.*)

REPORT PURPOSE CODE: 00 = Original First Report of Injury; 02 = Updated or Amended First Report.

RTW DATE (*Return to Work Date)*: Enter the date following the most recent disability period on which the employee returned to work.

SIC CODE: This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT / EXPOSURE: Describe the specific activity the employee was engaged in during the accident or exposure (*e.g. Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting*).

TYPE OF INJURY / ILLNESS: Briefly describe the nature of the injury or illness (*e.g. Contusion, Laceration, Fracture, etc.*)

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT / EXPOSURE: Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (*e.g. Building maintenance*).

INDIANA WORKER'S COMPENSATION
FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R10 / 1-02)

FOR WORKER'S COMPENSATION BOARD USE ONLY		
Jurisdiction	Jurisdiction claim number	Process date

Please return completed form electronically by an approved EDI process.

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION

Social Security number	Date of birth	Sex	Occupation / Job title	NCCI class code
xxx-xx-9777	12/26/1996	☒ Male ☐ Female ☐ Unknown		

Name (*last, first, middle*)	Marital status	Date hired	State of hire	Employee status
Nicolas Aaron Lopez-anderson	☒ Unmarried ☐ Married ☐ Separated ☐ Unknown	12/13/2022		Full Time

Address (*number and street, city, state, ZIP code*)	Hrs / Day	Days / Wk	Avg Wg / Wk	☐ Paid Day of Injury ☐ Salary Continued
2088 E Empire Ave Lot 135 Benton Harbor, MI 49022				

Telephone number (include area)	Number of dependents	Wage	Per
574-274-7074	0	$	☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year ☐ Other

EMPLOYER INFORMATION

Name of employer	Employer ID#	SIC code	Insured report number
Reinalt-Thomas Corporation			

Address of employer (*number and street, city, state, ZIP code*)	Location number	Employer's location address (*if different*)
20225 N Scottsdale Rd Scottsdale AZ 85255	Discount Tire - TRH001 / 7101 Vorden Telephone number: 480-606-6433	7101 Vorden Pkwy South Bend, IN 46628

Carrier / Administrator claim number	OSHA log number	Report purpose code

Actual location of accident / exposure (*if not on employer's premises*)
7101 Vorden Pkwy South Bend, IN 46628

CARRIER / CLAIMS ADMINISTRATOR INFORMATION

Name of claims administrator	Carrier federal ID number	Check if appropriate
Sedgwick Claims Management Services, Inc.		☐ Self Insurance

Address of claims administrator (*number and street, city, state, ZIP code*)		Policy / Self-insured number
PO Box 14156 Lexington KY 40512	☐ Insurance Carrier ☐ Third Party Admin.	
Telephone number		Policy period From To

Name of agent	Code number

OCCURRENCE / TREATMENT INFORMATION

Date of Inj./ Exp.	Time of occurrence	Date employer notified	Type of injury / exposure	Type code
5/24/2023	1:30 ☐ AM ☒ PM ☐ Cannot be determined		Eye Symptoms	

Last work date	Time workday began	Date disability began	Part of body	Part code
			Eye - Right	

RTW date	Date of death	Injury / Exposure occurred on employer's premises?	Name of contact	Telephone number
		☒ Yes ☐ No		

Department or location where accident / exposure occurred	All equipment, materials, or chemicals involved in accident
	Ink pen

Specific activity engaged in during accident / exposure	Work process employee engaged in during accident / exposure
Cutting shrink wrap off of a skid	

How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.
EE alleges approximately 20 minutes ago while cutting shrink wrap off of a skid, he was using an ink pen and the ink cartridge part flew out hitting him in the right eye.

Cause of injury code:

Name of physician / health care provider
Beacon Occupational Health LLC

Hospital or offsite treatment (*name and address*)

INITIAL TREATMENT
- ☐ No Medical Treatment
- ☐ Minor: By Employer
- ☐ Minor: Clinic / Hospital
- ☐ Emergency Care
- ☐ Hospitalized > 24 Hours
- ☐ Future Major Medical / Lost Time Anticipated

Name of witness	Telephone number	Date administrator notified

Date prepared	Name of preparer	Title	Telephone number

An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13).