Accident Investigation Kit

Accident Investigation Forms

1. Post-Accident Checklist
2. Employee Report of Injury
3. Supervisor Accident Investigation Summary
4. Witness Incident Report (2)
5. Medical Communications Authorization Form
6. Declination of Treatment
7. Sample Vendor Utilization Letter for Physician

AFGroup.com

AF Group AccidentFund UnitedHeartland CompWest ThirdCoast Underwriters

Post-Accident Checklist

If a serious trauma or medical condition occurred, seek immediate medical treatment or call 911.
For non-emergency accidents, ensure the injured employee(s) is directed to the designated occupational clinic and follow any drug or alcohol testing mandated by your company policy. Inform the physician that the company will attempt to accommodate modified duty work, if needed, and ask the physician to address the injured employee's work capabilities and/or recommended work restrictions.

1. Preserve the scene and gather details.

Preserve any/all failed equipment and evidence that may have contributed to the incident until the claim is fully investigated. Take photos of the scene or condition. Interview the injured person(s) to fully understand the extent of injury/injuries. Ask them to explain/demonstrate how, when, where and why the injury occurred.

2. Present the injured employee(s) with the following:

All written statements should be completed by the injured employee(s) in their own words, signed and dated.

- **Employee Report of Injury Form:** Ensure the information on the form is consistent with information shared during the interview. Discuss any discrepancies to understand where disconnect may have occurred during the interview. Request employee amend and clarify their statement as necessary to align with their verbal explaination.
- **Medical Communications Authorization:** At the time of reporting the incident, the injured person(s) should review and sign the medical communications authorization form. This document will allow us to obtain all necessary medical information to advance the claims handling process as quickly as possible.
- **Declination of Treatment:** In the event that an employee declines medical treatment following a workplace incident, inform them that an incident will be filed with the insurance carrier and the carrier may call them. In addition, explain that the company will follow up with them over the following days to confirm their condition is improving and eventually has resolved. If care is necessary, the company will assist them in seeking care. If care is not needed, the employee will be expected to sign the bottom portion of the Declination of Treatment affirming the injury has resolved without receiving treatment and everyone can close their file knowing the employee is well. **This process should be fully explained at the time the employee first declines treatment.**

3. Perform investigation summary.

All written statements should be completed by the supervisor in their own words, signed and dated.

- **Supervisor Accident Investigation Summary:** This report should include all relevant details about the incident and process/tool/systems failures. The supervisor's statement should reflect their own conclusions they considered all statements and physical evidence. *The supervisor's statement should reflect their own conculsions and should be completed by the supervisor in their own words, signed and dated.*

4. Identify witnesses and gather statements.

All written statements should be completed by each individual witness in their own words, signed and dated.

- **Witness Incident Report:** This report should include relevant details from the perspective of all witnesses. Follow the same statement gathering process for all witnesses.

5. Report the incident to your workers' compensation carrier.

Reporting the incident to your workers' compensation carrier (Accident Fund, United Heartland, Third Coast Underwriters or CompWest) within 24 hours of the incident helps ensure Claims teams can begin processing the incident as quickly as possible.

6. Other important details to share with the injured employee(s):

Find these and other resources on our website.

- Prescription first fill form, if pharmaceuticals are needed.
- Information on claim texting capabilities (including real-time language translation).
- Preferred vendor utilization letter template for physicians to streamline continuity of care for injured person(s).
- Digital Customer Portal (DCP) account access for billing, electronic funds transfer (EFT) sign up, receipt collection, claim handler notes, etc.

Employee Report of Injury

Form to be completed by the injured worker.

CONTACT

Name (first, middle, last): _____

Street address:_____ Suite/Apt./Other: _____City: _____ State:_____ Zip code: _____

Date of birth: _____ Social Security number: _____

Home phone: (_____)_____ Cell phone: (_____)_____ Work phone: (_____)_____

Email:_____ Emergency contact name :_____ Phone: (_____) _____

Primary language: English Spanish Polish Other : _____

PERSONAL

Height: _____ Weight: _____ Gender: Male Female Prefer not to disclose.

Marital Status: Single Married Widowed Divorced Other: _____ Number of dependents: _____ List dependent date(s) of birth or leave blank if not applicable: _____

Are you financially responsible for anyone else? (Y/N)_____ If yes, state whom you are responsible for and why: _____

EDUCATION

Highest level of education completed: GED High school Two-year degree Four-year degree Graduate degree or higher

Where did you complete your highest level of education? _____

List specializations/certifications: _____

EMPLOYMENT

Company name: _____ Supervisor: _____ Date of hire: _____

Job title: _____Weekly wage: _____ Hourly rate: _____ Hours per week: _____ Salary (if applicable): _____

Do you work overtime (O/T)? (Y/N): _____ If yes, how many O/T hours do you work weekly? _____ Is O/T mandatory? (Y/N) _____

Are you a member of a union? (Y/N): _____ If yes, name of union: _____ Year you became a union member: _____

Were you injured as a result of your employment with the above employer? (Yes/No) _____ If yes, list lost wages due to your injury: _____

SECONDARY EMPLOYMENT

If you had a second job at the time of your injury, provide employer name, address, phone: _____

If self-employed or own your own business, provide company name and nature of business: _____

INCIDENT INFORMATION

Date and time of incident: _____ Exact address/location where occurred: _____

Date reported to supervisor: _____ Name of supervisor(s) incident was reported to: _____

Supervisor(s) on duty at the time: _____

Describe step-by-step what led up to the incident and what you were doing when you were injured: _____

_____

_____

_____

Were you performing work duties as instructed? (Y/N): _____ If yes, who provided this instruction? _____

If you were not instructed to perform this duty, explain why you were doing it: _____

What would have prevented the injury? _____

_____

_____

List any unsafe conditions that contributed to your injury, if any:_____

If you were going to perform the same task again, state what you would do differently and why: _____

_____

_____

_____

TOOL/DEVICE FAILURE *(If not applicable, leave blank.)*

Did a tool/device failure contribute to or cause your injury? (Y/N) _____ If yes, explain: _____

_____

Identify the make, model and manufacturer serial number: _____

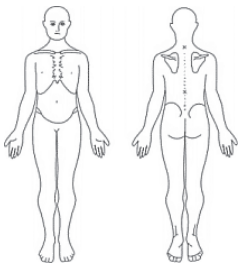
Were you instructed to use the tool/device? (Y/N)_____ If yes, who instructed you to use the tool/device? _____

Were you following instructions for proper usage? (Y/N) _____ Where is the tool/device located now? _____

_____

INJURY DETAILS

Draw an arrow pointing to any direct traumas. Place an "X" where you have pain, and describe the type of pain next to the affected area(s).



List all part(s) of your body that were injured:_____
_____
_____

Describe the type/nature of injury to each body part injured: _____
_____
_____
_____
_____

MEDICAL CARE

Were you hospitalized (Y/N)?_____ Which hospital?_____ How long?_____
List all physicians and facilities that have treated you for this injury (name, address, phone): _____
_____
Who is your current, primary treating physician? (name, address, phone): _____
When was your first doctor's appointment for this injury (not including hospitalization)? _____
When is your next doctor's appointment for this injury? _____ Is ongoing treatment or physical therapy required? (Y/N) _____

WORK RESTRICTIONS

Has a physician restricted you from working in any capacity as a result of this injury? (Y/N)_____ If yes, for how long? From _____ to _____
Has a physician authorized to take off work completely? (Y/N)_____ If yes, for how long? From_____ to _____
Do you have a possible return to work date? (Y/N)_____ When?_____ Did you present a doctor's note to your employer? (Y/N)_____
If yes, on what date did you present it and to whom?_____

MEDICAL HISTORY AND PRIOR WORK RESTRICTIONS

List any underlying health problems you have that may complicate your recovery (such as diabetes, hypertension, etc.): _____
_____
Have you ever had an MRI or CT-Scan? (Y/N) _____ If yes, on what body part(s), where were they performed, when were they performed, and what were the findings? _____
Did you previously injure any of these body parts? (Y/N)_____ If yes, state what body part was injured, what the previous diagnosis was, and when you were discharged from care for each condition: _____
_____
State with whom you treated for each condition: _____
Did any physician ever place a permanent restriction on you? (Y/N) ____ If yes, list the restriction placed on you, state who placed the restriction, and when: _____
_____
Have you ever filed for workers' compensation benefits before? (Y/N) _____ If yes, list the state where you filed for benefits, the employer you worked for at the time, and what the injury was that you sustained? _____
_____

WITNESSES

List all witnesses to the injury: _____
_____
_____

Outside earnings earned while receiving workers' compensation benefits must be immediately reported to the workers' compensation carrier. Promptly report any restrictions placed on you to your employer so they may attempt to accommodate your restrictions. Advise your physician that they must address what work you are capable of performing, or what restriction is required, if any, at every appointment. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

I certify I have read the information on this sheet and have answered the questions fully, truthfully and to the best of my knowledge.

Name (printed):_____Signature: _____ Date:_____

Supervisor Accident Investigation Summary

CONTACT

Name: _____ Job title: _____

Street address:_____ Suite/Apt./Other: _____City: _____ State:_____ Zip code _____

Phone: (_____)_____ Project name/location (if applicable): _____

How long have you been on this job site? _____How long has the injured employee been employed? _____

INJURED EMPLOYEE INFORMATION

Name of injured employee: _____Injured employee phone number: _____

Occupation of injured employee: _____

Nature of injury sustained (cut, broken bone, etc.): _____

Part(s) of body injured (be specific): _____

_____

Did employee miss days of work (Y/N)? _____ If yes, how many work days were missed?_____ Did the employee return to normal work schedule (Y/N)? _____ If yes, date of return: _____ Are/were modified job duties required (Y/N)? _____ If yes, explain: _____

_____

INCIDENT INFORMATION

Date and time of incident: _____ Exact address and details where injury occurred: _____

_____

What task was being performed at the time of the incident? _____

_____

What went wrong? _____

_____

_____

Were proper task instructions provided (Y/N)? _____ Was the employee following these instruction at the time of the incident (Y/N)? _____

Explain: _____

_____

_____

Did the employee utilize all safety equipment and follow all safety procedures at the time of loss (Y/N)? _____ Explain: _____

_____

_____

Who/what contributed to the accident? Explain: _____

_____

_____

Is there anything you will do differently as a supervisor as a result of this accident? _____

_____

_____

TOOL/DEVICE FAILURE *(Reminder: Always preserve evidence and take photos. Skip section if not applicable.)*

If tool/device failure occurred, identify the make, model and manufacturer serial number: _____

Where is the tool/device located now? _____

Was the employee instructed to use the tool/device?(Y/N) _____ If yes, were proper tool/device usage instructions provided? (Y/N) _____ If yes, who provided instruction? _____

WITNESSES *(Reminder: All witnesses should independently complete the Witness Incident Report form.)*

List names, addresses and phone numbers of all witnesses: _____

_____

_____

I certify I have answered the questions fully, truthfully and to the best of my knowledge.

Name (printed):_____Signature: _____ Date:_____

Witness Incident Report

Each individual witness should complete and sign this report. Do not include information you did not see or hear yourself.

Witness name/job title:_____Witness phone: _____

Witness address: _____

Name of injured person(s): _____

Date and time of incident: _____ Relationship to the injured employee: _____

Did you see the incident happen? (Y/N) _____ Describe the nature of the injuries sustained by the injured employee: _____

Describe in detail what you witnessed, how the accident occurred and include relevant events that led up to the incident: _____

Could this incident have been prevented? (Y/N) _____ If no, how could it have been prevented? _____

Did the employee utilize all safety equipment and follow all safety procedures at the time of loss? (Y/N) _____ Explain: _____

Who/what contributed to the accident? Explain: _____

Note any other important details here: _____

I certify I have answered the questions fully, truthfully and to the best of my knowledge.

Name (printed):_____Signature: _____ Date:_____

Witness Incident Report

Each individual witness should complete and sign this report. Do not include information you did not see or hear yourself.

Witness name/job title:_____Witness phone: _____

Witness address: _____

Name of injured person(s): _____

Date and time of incident: _____ Relationship to the injured employee: _____

Did you see the incident happen? (Y/N) _____ Describe the nature of the injuries sustained by the injured employee: _____

Describe in detail what you witnessed, how the accident occurred and include relevant events that led up to the incident: _____

Could this incident have been prevented? (Y/N) _____ If no, how could it have been prevented? _____

Did the employee utilize all safety equipment and follow all safety procedures at the time of loss? (Y/N) _____ Explain: _____

Who/what contributed to the accident? Explain: _____

Note any other important details here: _____

I certify I have answered the questions fully, truthfully and to the best of my knowledge.

Name (printed):_____Signature: _____ Date:_____

Medical Communications Authorization

I unconditionally authorize all medical doctors, licensed physicians, medical practitioners, surgeons, doctors of osteopathy, chiropractors, any medical related facilities, insurance companies, other organizations, corporations, institutions, or persons that have any records, knowledge or information, including my mental or physical health, history, condition or welfare, to supply all such information to my employer and its insurers, including Accident Fund Insurance Company of America, Accident Fund General Insurance Company, Accident Fund National Insurance Company, United Wisconsin Insurance Company, CompWest Insurance and Third Coast Underwriters, their third party claims administrators, attorneys, consultants, nurses and vendors which may participate in the evaluation and recruitment of information to determine my entitlement to benefits under any workers compensation or occupational disease acts, or in the coordination of medical or vocational rehabilitation. This authorization includes, but is not limited to, the furnishing and delivery of reproduced or photographic copies of notes, reports, records, intake form and films.

I expressly authorize any treating physician or other medical care provider to communicate orally or in writing with the above described entities regarding my past, present and future care and treatment, and to any other issues including but not limited to my diagnosis, prognosis, the causal connection of any injury or condition of ill being to my employment, treatment plan, nature and extent of injury, and my ability to work. I hereby waive any doctor-patient privilege resulting from any consultation, examination, or treatment with or by you, and any relevant regulations under the Health Insurance Portability & Accountability Act. In addition, any treating physician or medical provider is authorized to review and discuss any additional records, films or information provided to them.

I understand that the persons, organizations or above referenced entities that I am authorizing to share and communicate my information to may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits based on my decision to sign this authorization. I know that federal law may not protect my information once it is disclosed, and that my information may be shared with someone else after it is disclosed. I understand I have the right to rescind this authorization at any time, and that revocation of this authorization must be made in writing.
I know that any communications or actions made prior to the revocation of this authorization will not be impacted by a revocation.

A photocopy of this authorization shall be as valid as the original. This release will remain valid for the duration of my worker's compensation or occupational disease claim, unless expressly rescinded in writing. I understand that after signing this authorization, I will be provided with a copy
of it.

I have read and understand the information contained in this medical and communications release.

Social Security Number: _____ Date of Birth: _____

Signature: _____ Date: _____

Print Name: _____

Address: _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Declination of Treatment

It is our policy to provide prompt and appropriate medical treatment to employees for work related injuries. There are situations that arise where notice of an injury may be made, and formal treatment may not be necessary.

When an employee reports a work related injury, the injury will be documented and treatment will be offered. An employee may indicate a preference not to have formal medical treatment. In the event that an employee declines medical treatment, we will have the employee sign this document indicating that they declined medical treatment. The company will continue to monitor the resolution of the complaints or injury until the time that the condition has been completely resolved. The employee will be asked to sign off that the condition has completely resolved.

In the event that a condition is not improving readily during the monitoring period, or should the condition worsen, the employee will be sent for an evaluation to make sure the condition is properly addressed. There may be situations where an employee is sent for a medical clearance examination following their report of injury, even though the injured employee has declined medical treatment.

Date of Injury: _____

Injured Employee's Name _____

Supervisor's Name: _____

Body Part(s) Injured: _____

I am declining medical treatment at this time. Should my condition worsen or should I change my mind regarding treatment, I acknowledge I must inform my supervisor immediately. Date: _____

Injured Employee's Signature: _____

Supervisor's Signature: _____

My injury/injuries have completely resolved. Date: _____

Injured Employee's Signature: _____

Supervisor's Signature: _____

Sample Vendor Utilization Letter to Physician

Providing key information to treating providers up-front can help improve preferred vendor utilization and streamline and improve the continuity of care for injured workers. **To request a letter with the most current billing and provider referral information, contact your dedicated claim representative.**

April 17, 2023

Provider Name
123 South Main Street
City, State, 48823

Email/Fax: xxx-xxx-xxxx

RE:
DOB:
Injury/Body Part:
Date of Injury:
Employer:
Claim Number:

Dear Treating Provider,

We have an open and billable claim for the injured worker referenced on th
**forward a copy of your medical chart and bills for the treatment of the
consideration – and accept this as an ongoing request for a faxed wo
following each visit.**

Note: The employer will do everything possible to return their injured worke

Should medical services be required, please expedite the process by initia
providers listed on the enclosed form. Once the referral is made, the ancill
undersigned for prompt authorization, where allowed by law. Use of these
some states.

Feel free to contact the undersigned with an

Sincerely,

[Full contact info ... al fax

Enclosure: Billi ... ovider Referral Information

United Heartland is the marketing name for United Wisconsin Insurance Company, a division of AF Group. All policies are
For more information, visit afgroup.com. © AF Group.

Billing and Ancillary Provider Referral Information

RE:
DOB:
Injury/Body Part:
Date of Injury:
Employer:
Claim Number:

Medical Serv

		Phone	Fax	
Phys ...	One Call ...	877-225-67	904-394-8369	...onecallcm.com
	MedRisk ... MD, MS	800-225-967		medriskreferrals@medrisknet.com
	...hid Medi	866-888-6724	866-246-8587	referrals@orchidmedical.com
...gnostic ... an, EMG	... America	877-512-5742	954-343-1779	AFGroup@MTIamerica.com
	...Call Care Management	877-225-6785	904-394-8369	AFGroup@onecallcm.com
Durable Medical Equipment (Medical Supplies and Home Health)	Orchid Medical	866-888-6724	866-246-8587	referrals@orchidmedical.com
	VGA Homlink	877-711-3171	844-851-6419	AFGroupHomelink@vgm.com
	MTI America	877-512-5742	954-343-1779	afgroup@MTIamerica.com
	Northwood Included states: GA, IA, IL, IN, KS, MI, MN, MO, MS, NC, TN	877-684-9275	866-895-7207 x2550	referral@northwoodinc.com
	Optum	844-880-0565	800-419-7194	owcaorders@optum.com

Pharmacy

Pharmacy	My Matrixx				
PCN	WC	Bin Number	003858	Processor	A4
United Heartland Group Number	KQSA				
Compound creams require a letter of medical necessity and pre-authorization, except where precluded by law.					

Billing

AF Group Billing Address	**AF Group – Third Coast Underwriters** PO Box 40790, Lansing, MI 48901
Questions regarding bill status should be directed to Provider Relations at 866-206-5851.	
Medical Bill Electronic Clearinghouse	WorkComp EDI 4250 Veterans Memorial Hwy, Ste. 301E Holbrook, NY 11741
WorkComp EDI Customer Service Contact	**Marisa Nappi** **Phone:** 800-297-6909 x1303 // **Fax:** 631-648-6023 // **Email:** info@workcompedi.com
WorkComp EDI Payer Numbers	United Heartland / WB471

United Heartland is the marketing name for United Wisconsin Insurance Company, a division of AF Group. All policies are underwritten by a licensed insurer subsidiary.
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