Workers Compensation Modifier Controllers, Inc.

Specialists in Reducing Workers Compensation Costs

426 Hayward Ave North
Oakdale, MN 55128
Phone (651) 501-1490
Fax (651) 501-1493

Thomas Allen, Inc.
Supervisor Checklists

In order to establish accurate and timely procedures for reporting of workers compensation claims please follow the following list.

1. Immediately fill out the Claim Information Report. Fill in as much information as possible and immediately fax to our office. It is better to send it partially completed than to hold it until you have everything filled in. You may also email claims to Claims@WCMCINC.com

2. If possible have the employee come to your office to sign the release forms. At that time if they have not yet sought medical attention, supply them with the Light Duty Form and explain they are to give it to the treating physician and return it to you immediately. It is the responsibility of the injured employee to return this form to you immediately upon completion of a medical visit. They should take a copy of this form to each and every medical visit.

3. Inform the employee that light duty work will be available to meet basically any restrictions the doctor may feel appropriate and that they will be required to work light duty.

4. Ask the employee to bring all medical papers to your office so they can be copied and or faxed to us immediately.

5. Keep updated notes on all comments, job refusals, refusals of employment, or statements that may have a bearing on this claim. Via phone messages, fax machine, e-mail or by mail advise WCMC of all of this information.

6. Stay in constant contact with WCMC regarding status or information you receive on this injury.

Please remember it is the responsibility of the employer, not the employee, to fill out the Claim Information Report. The employee is not required to physically come in to your office to advise you of an injury. It is the requirement of the employer to immediately notify us of the claimed injury.

Call WCMC at 1-651-501-1490 with any questions.

Dave J. Samuel
President

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Thomas Allen, Inc.
Claim Information Report

When notified of an injury, immediately complete all information you have. Completed form to be fax to 651- 501-1493 or email to claims@WCMCINC.com within 24 hours.

To be completed at initial claim intake.

Full Name:_____Site Location_____
Phone: (_____)_____-_____ Cell Phone:(____)____-_____Email_____
Date of Injury: _____ Date Employer Notified of Injury:_____
Time of Injury:_____ AM/PM Scheduled shift on Date of Injury:_____
Did employee leave work early?_____ Time left: _____ AM/PM
Type of Injury:_____ Employee's activities when injured:_____
_____
_____
Job title:_____Work Site location_____
Address of Injury Site:_____
_____
Hospital/Clinic:_____
Witnesses:_____ Witness Phone # _____
Employee's Supervisor Name:_____
Supervisor Phone Number:_____
Supervisor Email:_____
Completed by:_____Date:_____

To be completed by Employer:

Employee Social Security#:_____ DOB:_____
Employee's Address: _____ City _____ State _____ Zip _____ Single/Married (circle one)
Hire Date:_____Job Title:_____
Wage:_____ Full or Part Time Employee (circle one)
First Day of Lost Time:_____ Return to Work Date:_____
Employee's weekly scheduled hours:_____
_____
_____

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NOTE: WCMC is excluded from the definition of "health plan" in the privacy rules developed pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is not a covered entity. However, this authorization meets the core elements set forth in the HIPAA privacy rule, Section 164.508 (c).

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

TO: **RE:**
DOB:

This is your full and sufficient authorization, pursuant to Minn. Stat. § 144.291 - 144.298, to release to:

WCMC, Inc. and/or its agent: Thomas Allen, Inc.
426 Hayward Ave North 1550 Humboldt Ave.
Oakdale, MN 55128 West St. Paul, MN 55118

their representatives or employee, all medical information (including but not limited to that which involves treatment for alcohol or drug abuse, sickle cell anemia, or mental problems) maintained while I was a patient at your facility on any date, including: Physical Exam/Laboratory Data, History, Psychological Evaluation/MMPI, Psychiatric Evaluation, psychotherapy records, Medical Progress Notes, X-ray Reports, films, radiology studies, Continuum of Care Plan, or any other type of medical record, with the following exceptions: _____.

This information is needed for the purpose of: WORKERS' COMPENSATION LITIGATION.

This authorization specifically includes records prepared prior to the date of this authorization and records prepared after the date of this authorization during the pendency of this proceeding (including claims and potential claims). I understand that protected health information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and there may be a loss of protection under the Federal privacy rule or HIPPA.

I understand that I may revoke this consent in writing at any time, but that such revocation may adversely affect the course of the proceeding requiring these records and that revocation will not have any effect on the information released prior to notification of revocation. Upon the fulfillment of the above-stated purpose, this consent will automatically expire without my express revocation. A photocopy of this authorization will be treated in the same manner as an original. Conversations by the bearer of this authorization with physicians, however, are/are not **(strike one)** authorized by this release form.

HIPAA privacy rules specifically allow covered entities to disclose protected health information as authorized and to the extent necessary to comply with law relating to workers' compensation programs. See 45 CFR 164.512 (1).

_____ _____
Date Signature of Patient/Guardian

_____
Relationship to Patient

_____
Reason Patient is Unable to Sign

I verify that the proceeding requiring this information is still pending and that information provided pursuant to this authorization will not be re-released for purposes not related to this proceeding. The patient=s treatment, payment, enrollment or eligibility of benefits may not be conditioned on executing this authorization.

_____
Signature of Party Requesting Information Date

ATTENTION PUBLIC FACILITIES: **Minnesota Statute § 13.05 requires automatic expiration of this authorization one year from the date of authorization.** Form approved by Minnesota State Medical Association, Minnesota State Hospital Association, Minnesota State Bar Association, and Minnesota Association of Hospital Attorneys.

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AUTHORIZATION FOR FILE REVIEW OR RELEASE OF COPIES OF WORKERS' COMPENSATION CLAIMS FILE

EMPLOYEE:

SSN:

DOI: ANY AND ALL

I hereby authorize, Thomas Allen, Inc. and/or its agent WORKERS COMPENSATION MODIFIER CONTROLLERS, INC., to review and/or obtain copies of any or all parts of the Minnesota workers' compensation claim file(s), for the date(s) of injury as indicated.

Dated:_____ By:_____

Information concerning disability may not be used to make a job decision unless state or federal law requires use of this information. Any use or distribution of this information beyond that authorized by the subject of this data unless authorized by state or federal law is prohibited. Questions concerning use of disability information may be directed to the Minnesota Department of Human Rights at (612) 296-5663 or toll-free in greater Minnesota at 1-800-652-9747.

MN

Dave J. Samuel
President

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AUTHORIZATION AND CONSENT TO RELEASE INSURANCE RECORDS AND INFORMATION

To:

Claimant:

SSN:

Insured:

Claim No:

I, the undersigned, agree to allow Thomas Allen, Inc. and/or its agent Workers' Compensation Modifier Controllers, Inc (WCMC) or any of their agents to review and photocopy any and all information contained in the claim file of the insurance company set forth above, including all payments made under said policy, re-release of any medical records, reports, letters and opinions from any and all medical or chiropractic providers, all statements of parties or witnesses, signed or unsigned, typed, handwritten or audio recorded, pleadings, State Workers' Compensation Forms, and discovery documents. This authorization will be good for a period of one (1) year from the date hereof.

Furthermore, I agree that a photocopy of this authorization will have the same force and effect as the original.

Dated: _____ By: _____

Dave J. Samuel
President

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EMPLOYMENT AUTHORIZATION AND CONSENT

TO:

RE:

SSN:

Please give Thomas Allen, Inc. and/or its agent WORKERS COMPENSATION MODIFIER CONTROLLER, INC., any and all information with respect to my employment with your company. This includes the examination of any and all of my personnel, attendance, sick leave, vacation days, wage records, employment application, and job descriptions and the copying thereof. I am willing that a photocopy of this Employment Authorization and Consent be accepted with the same authority as the original.

Dated this_____day of_____, 20___.

By_____

Dave J. Samuel
President

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LIGHT DUTY AVAILABLITY

Today's Date_____ Injury Date_____

Employee Name_____

Thomas Allen, Inc. has temporary transitional light duty work available to meet restrictions. This includes the availability of reduced hours, one handed work as well as sit down work with no bending or twisting. Please contact our workers compensation specialists at (651) 501-1490 with any questions.

*We respectfully request that no employee capable of some type of light duty work be totally disabled.

Diagnosis_____

Restrictions_____

Restrictions Effective Until:_____

Scheduled follow up:_____

Physician(Printed)_____(Signature)_____

Clinic/Hospital_____

The patient is to return this form to Thomas Allen, Inc. immediately. Please fax this form directly to 651-501-1493.

Dave J. Samuel
President