



Highview
A Muller Company

WORKERS COMPENSATION

WELCOME PACKAGE
AND CLAIM KIT
NEW JERSEY

NEW JERSEY

NEW JERSEY

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Dear Policyholder:

Thank you for placing your workers' compensation coverage with Highview National Insurance Company (HNIC). We look forward to providing you with superior customer service and compassionate care for your injured workers.

Enclosed you will find important information and instructions regarding workers' compensation requirements and the claims process.

The form **16-New Jersey A, Posting Notice**, should be printed on letter sized paper, completed, and posted in one or more conspicuous places at each business location. Also included are your **HNIC 24/7 Work Injury Nurse and Telehealth Line posters and the HNIC Mandatory Pharmacy Benefits Notification** which should also be posted in one or more conspicuous places at each business location.

You will also find documentation necessary for the processing and administration of a claim in the event of a workplace injury. Please use these documents to collect all information regarding the injured employee and incident and send the documents when reporting a claim and/or upon request. The assigned claims professional will forward necessary documentation to the appropriate state entity.

To mitigate the cost of claims, it is critical that you immediately investigate, document, and report, all workplace injuries.

For fastest claims processing, please use our online reporting tool:

- Login to your account at www.highviewins.com
- Click Incidents, then New Incident to enter the claim
- Upload all forms and claim related documents

Should online reporting not be available or you do not have access to the internet, you can call 833-281-0215 24/7. When doing so you will be directed to a registered nurse who will ask you the nature of the injury to the employee, how it happened, where and when it happened, medical treatment provided, both you and the employees contact information and the names of any witnesses as well as their contact information.

Claims also be reported via fax at 845-363-0500 or via email at claims@highviewins.com.

If an employee has a severe injury and needs immediate medical assistance, please call 911.

If an employee needs treatment for any other alleged injury, please have them call 833-281-0215 to speak with a nurse. The nurse will assist by arranging a telehealth or onsite physician appointment, as appropriate. Please note that this is NOT a substitute for reporting claims.

Along with the posters and notifications mentioned above, your package also includes the following forms that should be filled out and sent to Highview National Insurance Company as soon as possible or as soon as you are directed to by the adjuster handling the claim.

Completed forms should be sent either by email, fax, overnight or standard mail.

Forms included:

Employer's First Report of Work-Related Injury or Illness with Instructions (Form LWC-WC-IA-1). A work-related injury or illness must be reported within 14 days (Per Section 34:15-17) of the injury/illness. *Employers have the right to direct initial and subsequent medical treatment.*

As soon as your employee has suffered an injury a copy of the **Highview National Insurance Company Employee Injury Checklist** should be provided to the injured employee. This will assist both the employee in seeking the assistance necessary, and any medical provider that the checklist is shared with.

As soon as the employee is capable, they should fill out the **Highview National Insurance Company - Employees Accident Report** which, in their words, describes the injury or accident. Also, please provide the **Highview National Insurance Company - Supervisors Report** to either the employee's supervisor or manager as well as the **Highview National Insurance Company - Witness Statement** to any witnesses to the accident which should be completed, signed, and returned to you.

For HNIC to gather the information necessary for medical treatment, the employee will need to sign the **Highview National Insurance Company - Release of Information** form and should be provided the **Highview National Insurance Company First Fill Letter** for any prescriptions that need to be filled.

Should you have any questions regarding the contents of this kit, a claim, or claim reporting, please contact us via phone at (845) 363-0500 or via email at info@highviewins.com. Questions regarding your insurance policy or coverage should be directed to your broker or representative.

POSTING NOTICE

Form 16-NJ A

The law requires every insured employer to post and maintain notices naming the company insuring its compensation liability "in a conspicuous place or places in and about the employer's place of business." The form of notice is prescribed by the Commissioner of Banking and Insurance and shall be clearly printed on a minimum of 90# index or on standard stock copy paper, 8 1/2" by 11" in size. The company insuring its compensation liability may, upon request, send the notice electronically to the employer. The content and arrangement of items must be consistent with the layout shown below. In accordance with 3:2-1 a duplicate filing must be made before the form is placed in use.

NOTICE

The undersigned employer hereby gives notice that the payment of compensation to employees and their dependents has been secured in accordance with the provisions of the Employer's Liability Insurance Law , Title 34 , Chapter 15 , Article 5 , Revised Statutes New Jersey, by insuring with the

(Highview National Insurance Company) Insurance Company

for the period

Beginning

Ending

Employer

In accordance with the above cited law , notice of compliance must be posted and maintained conspicuously in and about the employer's workplaces.

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE	
		JURISDICTION		JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER			
INDUSTRY CODE		EMPLOYER FEIN	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		
			LOCATION #	PHONE #	
CARRIER/CLAIMS ADMINISTRATOR					
CARRIER (NAME, ADDRESS, & PHONE #)		POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)		
		TO			
		CHECK IF APPROPRIATE			
		SELF INSURANCE			
CARRIER FEIN	POLICY/SELF-INSURED NUMBER		ADMINISTRATOR FEIN		
AGENT NAME & CODE NUMBER					
EMPLOYEE/WAGE					
NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)		SEX	MARITAL STATUS	OCCUPATION/JOB TITLE	
		M MALE F FEMALE U UNKNOWN	U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN	EMPLOYMENT STATUS	
PHONE		# OF DEPENDENTS	NCCI CLASS CODE		
RATE PER:	DAY WEEK	MONTH OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?	YES NO YES NO
OCCURRENCE/TREATMENT					
TIME EMPLOYEE BEGAN WORK	AM PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE () CANNOT BE DETERMINED	AM PM	LAST WORK DATE
					DATE EMPLOYER NOTIFIED
					DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER		TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED	
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE	
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL					CAUSE OF INJURY CODE
DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?		YES NO YES NO	
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)		INITIAL TREATMENT	
				0 NO MEDICAL TREATMENT	
				1 MINOR: BY EMPLOYER	
				2 MINOR CLINIC/HOSP	
				3 EMERGENCY CARE	
				4 HOSPITALIZED > 24 HOURS	
				5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	
OTHER					
WITNESSES (NAME & PHONE #)					
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE		PHONE NUMBER	

EMPLOYER'S INSTRUCTIONS
DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

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

AGENT NAME & 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.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.



EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.



CLINICALCARE24

**Injured at Work?
Report your injury to your supervisor
Then call the Nurse Triage line at**

833-281-0215

Nurse Triage Service Available 24/7/365

**IF IT'S AN EMERGENCY,
CALL 911**



Mitchell ScriptAdvisor

FAST & SIMPLE: GETTING YOUR FIRST PRESCRIPTION FILLED

Mitchell ScriptAdvisor has been selected by Highview National Insurance Company to assist you in obtaining prescription drugs related to your claim. This form enables you to fill prescriptions written by your authorized physician for medications related to your injury. Simply present it at the pharmacy at the time your prescription is filled. This form should ensure that you will have NO out-of-pocket expenses.

Please Note: This is a temporary prescription card; you may receive a permanent drug card in the future.

For your convenience, Mitchell ScriptAdvisor has an extensive network of retail pharmacies including major chain drug stores. For pharmacy locations, you may call our toll-free number at 866.846.9279 or visit our website at <https://portal.mitchellscriptadvisor.com/main/pharmacylocator.aspx> to access the pharmacy locator.



Employee

- You may contact Mitchell Customer Service at 866.846.9279 or you may present this sheet to the pharmacist along with your prescription.



Pharmacy

- This sheet is a Temporary Prescription ID Card for a **10 Days'** Supply Fill until this individual's permanent card can be provided.
- **Create the ID number** based off the criteria provided and write it, along with individual's name, on the ID card below.
- All data needed to process this script through the Script Care Adjudication System is included in the drug card represented below.

Mitchell ScriptAdvisor

Temporary Prescription Benefit Card



Attention Pharmacists: Process through Script Care and Enter RxBIN, RxPCN and GROUP.

Member Name:

Member ID #:

Date of Injury + Date of Birth (Example: MMDDYYMMDDYY)

Rx BIN: 023377

PCN: MPS

Group: 001806TC

Questions? Need Help?



Call (866) 846-9279

Our representatives are available 24/7 to answer any questions you may have regarding your pharmacy benefits.

This card is to be used for prescriptions related to your injury covered under your insurance policy. Use of this card does not waive any limitations or exclusions for the policy. This card does not confirm coverage. To confirm eligibility or obtain specific information, please contact the Help Desk with the information from the front of this card.

Mitchell ScriptAdvisor

RÁPIDO Y SIMPLE: OBTENER SU PRIMERA RECETA SURTIDA

Mitchell ScriptAdvisor ha sido seleccionado por Highview National Insurance Company para ayudarlo a obtener medicamentos recetados relacionados con su reclamo. Este formulario le permite surtir recetas escritas por su médico autorizado medicamentos relacionados con su lesión. Simplemente preséntelo en la farmacia en el momento en que se surta su receta. Este formulario debe garantizar que NO tendrá gastos de bolsillo.

Tenga en cuenta: Esta es una tarjeta de prescripción temporal; es posible que reciba una tarjeta de medicamentos permanente en el futuro.

Para su comodidad, Mitchell ScriptAdvisor tiene una extensa red de farmacias minoristas, incluidas las principales cadenas de farmacias. Para ubicaciones de farmacias, puede llamar a nuestro número gratuito al 866.846.9279 o visitar nuestro sitio web en <https://portal.mitchellscriptadvisor.com/main/pharmacylocator.aspx> para acceder al localizador de farmacias.



Empleado

- Puede comunicarse con el Servicio al Cliente de Mitchell al 866.846.9279 o puede presentar esta hoja al farmacéutico junto con su receta.



Farmacia

- Esta hoja es una tarjeta de identificación de prescripción temporal para un suministro de **10** días hasta que se pueda proporcionar la tarjeta permanente de esta persona.
- Cree el número de identificación basado en los criterios proporcionados y escríbalo, junto con el nombre del individuo, en la tarjeta de identificación a continuación.
- Todos los datos necesarios para procesar este script a través del Sistema de Adjudicación de Script Care se incluyen en la tarjeta de medicamentos que se representa a continuación.

Mitchell ScriptAdvisor

Temporary Prescription Benefit Card



Attention Pharmacists: Process through Script Care and Enter RxBIN, RxPCN and GROUP.

Member Name:

Member ID #:

Date of Injury + Date of Birth (Example: MMDDYYMMDDYY)

Rx BIN: 023377

PCN: MPS

Group: 001806TC

Preguntas? Necesita Ayuda?



Call (866) 846-9279

Our representatives are available 24/7 to answer any questions you may have regarding your pharmacy benefits.

Esta tarjeta debe usarse para medicamentos recetados relacionados con su lesión cubierta por la póliza de seguro. El uso de esta tarjeta no renuncia a ninguna limitación o exclusión de la póliza. Esta tarjeta no confirma la cobertura. Para confirmar la elegibilidad u obtener información específica, comuníquese con la mesa de ayuda con la información que se encuentra en el anverso de esta tarjeta.



Mitchell International
866.846.9279
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Employee's Accident Report
To be completed by the injured worker

Employee Name	
Employer Name	
Date of Accident	
Time of Accident	

Time you began work on day of accident	
Location of Accident (<i>specify if off-site address</i>)	

How did the injury occur? What job duties was the employee performing? Please describe in your own words

What part(s) of your body was injured (indicating right and/or left)?

--

Has the employee sought any medical treatment for these injuries? If so, specify where and when.

--

Have you ever injured this part of your body before (yes or no)? If so, please describe how and when the previous injury(s) occurred.

--

What witnesses were present when the accident occurred? Please provide names if applicable.

--

Who did you report the injury to? When was the injury reported? Please provide name(s) and job title(s).

--

What did you do after the accident occurred?

The above report is true and correct:

Prepared by:	Title:	Date prepared:

Supervisor's Report of Employee Accident

Employee Name		
Employer Name		
Date of Accident		
Time of Accident		
Date Accident Reported		
Did the employee report the accident immediately?	YES	NO
Location of Accident (<i>specify if off-site address</i>)		
How did the injury occur? What job duties was the employee performing?		
What part(s) of the employee's body were reported as injured?		
Has the employee sought any medical treatment for these injuries? If so, specify where and when.		
What witnesses were present when the accident occurred (including self)?		
Do you have any reason to question the legitimacy of the accident? If so, please explain:		
Any other info to share?		

The above report is true and correct:

Prepared by:	Title:	Date prepared:

Witness' Report/Statement of Employee Accident

Employee Name	
Witness Name, Title, & Phone	
Witness Address	

Date of Accident	
Time of Accident	
Location of Accident (specify if off-site address)	

Did you witness the above-reported accident? If so, how did the injury occur? What job duties was the employee performing?

What part(s) of the employee's body were injured? Describe the type of injury (strain, bruise, etc.)

What did the injured employee say at the time of injury? Did the injured employee complain of pain at the time of injury? If they complained of pain, please specify the body part(s).

What did the employee do after the accident occurred?

Were any other witnesses present at the time of the accident? If so, please list them below.

The above report is true and correct:

Prepared by:	Title:	Date prepared:
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NOTE: Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties.

Accident Investigation



The goal of accident investigation is to determine the root cause of an event in order to implement corrective measures to prevent recurrence of similar accidents.

The **ROOT CAUSE** is the initiating event in the sequence of events leading to the accident that if removed, would have prevented it from happening. The root cause is **NOT** the direct cause of the accident. Root causes are often confused with surface causes, which are symptoms of the root cause and are discovered along the way to determining the root cause.

HOW DO YOU KNOW IF YOU HAVE REACHED THE ROOT CAUSE?

It is helpful to establish an event chain, beginning with the direct cause and working your way through the symptoms until the root cause is determined. If you can still ask ‘why’, you have likely not yet reached the root cause. The reporting form provides a listing of root causes to select from.

ACCIDENT INVESTIGATION EXAMPLE (WITH EVENT CHAINS):

An employee slips and falls due to water collecting on the floor from a leaking pipe, which could have been discovered and fixed had someone inspected the facility for hazards. If there are no procedures in place to ensure regular inspections, “no inspection procedures” is the root cause of this accident and the accident investigation chain is as follows:



If instead, someone was supposed to conduct an inspection, but did not, “procedures not followed” is the root cause and the accident investigation chain is as follows:



Finally, if **CORRECTIVE ACTION(S)** have not been executed, the accident investigation process is not complete. Incidents should be reviewed with all department employees to assist in avoiding the same accident re-occurring with a different employee, as should any resulting corrective action policies/procedures. While re-trainings on existing procedures may sometimes be a necessary and important loss control response, on their own they are the least effective corrective action method. Physical and procedural controls, such as footwear requirements, machine guards, re-assigning a caregiver to no longer work with a specific combative resident, observing the employee to confirm correct practices are being followed, and establishing accountability and disciplinary procedures (discipline not necessarily for the injured employee, but for the employee who failed to adhere to the policy in question) are far more effective and should be implemented whenever possible.

APPLYING TRAINING AND PHYSICAL /PROCEDURAL CONTROLS FOR EACH ROOT CAUSE IDENTIFIED IS BEST PRACTICE.

HNIC will provide guidance, as needed, on each claim submission to ensure the root cause is discovered and appropriate corrective action(s) implemented in response to both the symptoms and the root cause. The form itself is designed to guide you to provide this necessary information.

Root Cause Analysis & Corrective Action Response

Are there specific procedures in place relating to this incident?

Yes No

- If YES, procedures are in place:
- Who is responsible/accountable for compliance with the procedures? _____
 - Were the procedures followed? Yes No
 - If NO, procedures were not followed:
 - Was there training provided on the procedures? Yes No
 - If YES, training was provided:
 - How often? _____
 - When was it last administered to the employee(s) involved? _____
 - Is there a discipline/corrective action policy for failure to follow the procedures? Yes No
 - If YES, there is a discipline policy:
 - Please describe: _____
 - Was it applied to the employee(s) identified above as responsible/accountable for compliance? Yes No

Root Cause Determination

- | | |
|--|---|
| <input type="checkbox"/> NO INSPECTION PROCEDURES
<input type="checkbox"/> GAP IN INSPECTION PROCEDURES
<input type="checkbox"/> INSPECTION PROCEDURES NOT FOLLOWED
<input type="checkbox"/> NO SAFE PATIENT HANDLING PROCEDURES
<input type="checkbox"/> GAP IN SAFE PATIENT HANDLING PROCEDURES SAFE PATIENT
<input type="checkbox"/> HANDLING PROCEDURES NOT FOLLOWED
<input type="checkbox"/> COMBATIVE RESIDENT BEHAVIOR - NO IDENTIFIED TRIGGER
<input type="checkbox"/> COMBATIVE RESIDENT BEHAVIOR - IDENTIFIED TRIGGER
<i>PLEASE DESCRIBE IDENTIFIED TRIGGER HERE</i> | <input type="checkbox"/> NO DE-ESCALATION PROCEDURES DE-ESCALATION
<input type="checkbox"/> PROCEDURES NOT FOLLOWED
<input type="checkbox"/> NO APPLICABLE PPE/FOOTWEAR REQUIREMENTS
<input type="checkbox"/> REQUIRED PPE/FOOTWEAR NOT WORN
<input type="checkbox"/> NO RESIDENT SPECIFIC CARE PLAN IN PLACE
<input type="checkbox"/> GAP IN RESIDENT SPECIFIC CARE PLAN
<input type="checkbox"/> RESIDENT SPECIFIC CARE PLAN NOT FOLLOWED
<input type="checkbox"/> NO APPLICABLE POLICIES/PROCEDURES
<i>PLEASE DESCRIBE APPLICABLE PROCEDURES</i> |
| <input type="checkbox"/> GAP IN APPLICABLE POLICIES/PROCEDURES
<i>PLEASE DESCRIBE APPLICABLE PROCEDURES :</i> | <input type="checkbox"/> APPLICABLE POLICIES/PROCEDURES NOT FOLLOWED
<i>PLEASE DESCRIBE APPLICABLE PROCEDURES</i> |

Root Cause Corrective Actions

- | | |
|---|--|
| <input type="checkbox"/> REVIEWED PROPER PROCEDURES WITH EMPLOYEE ENSURED EMPLOYEE'S UNDERSTANDING
<input type="checkbox"/> OBSERVED EMPLOYEE PERFORMING PROCEDURE(S) PROPERLY
<input type="checkbox"/> REVIEWED INCIDENT WITH ALL DEPARTMENT EMPLOYEES EMPLOYEE
<input type="checkbox"/> DISCIPLINED FOR DISREGARDING PROCEDURES
<input type="checkbox"/> ACCOUNTABILITY/RESPONSIBILITY/RISK OWNER ASSIGNED
<i>PLEASE PROVIDE NAME AND JOB TITLE OF ACCOUNTABLE PARTY HERE:</i> | <input type="checkbox"/> ESTABLISHED INCENTIVE PROGRAM TO ENCOURAGE COMPLIANCE WITH PROCEDURES
<input type="checkbox"/> ESTABLISHED TRAINING(S)
<input type="checkbox"/> INCREASED TRAINING FREQUENCY
<input type="checkbox"/> NOTED RESIDENT'S CARE PLAN
<input type="checkbox"/> ADJUSTED OR EXPANDED EXISTING PROCEDURES
<i>PLEASE DESCRIBE 'ADJUSTED OR EXPANDED EXISTING PROCEDURES' HERE:</i> |
| <input type="checkbox"/> ESTABLISHED NEW PROCEDURES
<i>PLEASE DESCRIBE 'NEW PROCEDURES' HERE</i> | <input type="checkbox"/> OTHER
<i>PLEASE DESCRIBE 'OTHER' HERE</i> |

THE ABOVE REPORT IS TRUE AND CORRECT

PREPARED BY:	TITLE:	DATE PREPARED:



First Aid Treatment Authorization
(Employee Copy)

Date:
Employee:
Job Title:
Claim Number:
Injury Date:
Employer:

The above, noted employee, _____
requests medical treatment at your clinic/hospital for injury to the following body part[s]
_____.

THIS WILL SERVE AS AUTHORIZATION FOR INITIAL EVALUATION AND TREATMENT AND WILL BE PAID IN ACCORDANCE WITH THE NEW JERSEY WORKERS' COMPENSATION FEE SCHEDULE.

If the employee can return to work without restrictions, please give the employee a full duty release note.

The employer may offer temporary transitional duty and may be able to accommodate medical work restrictions. If it's your medical opinion that the employee is unable to return to work to full duty, please complete the attached *Work Assessment Form*.

Paper Bill Submission:
Highview National Insurance Company
PO Box 2936
Clinton IA 52733

Fax Line: +1(845) 422-9994

Electronic Bill Submissions:
Payer ID: J4588
Clearinghouse: Jopari Solutions

Provider Inquiries / Provider Contact Center (Client Dedicated Line): (877) 547-9955

WORKERS' COMPENSATION FRAUD STATEMENT: Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT, or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Employee Name: _____
Employer Name: _____

Date of Injury: _____
Date of Birth: _____

I hereby authorize Highview National Insurance Company their representative or bearer, to review, inspect, copy, and/or photograph any and all of the following documents:

1. Any and all medical records, including but not limited to office and hospital records, laboratory results, diagnostic reports and films, psychiatric records, medical correspondences, doctor's and nurse's notes, and medical histories relevant to my workers' compensation claim. I also hereby give permission to Highview National Insurance Company representatives to contact the attending physicians involved in the treatment of all related conditions.
2. All employment and human resource information including but not limited to: hiring and employment records, payroll and income statements, documentation related to this or any other relevant injury and any other information pertinent to providing benefits and services necessary for the completion of this claim.

The released information is required for the following reasons:

1. To provide for adequate preparation, investigation, evaluation, review, and discovery of a claim for workers' compensation benefits. Specifically, to determine the causation and the nature and extent of any possible pre-existing, concurrent or aggravating medical conditions with potential medical, legal, or factual implications in this work-related injury or injuries.
2. To provide the treating physician, consultant or evaluator with medical information necessary to provide you with the best possible medical care and medical advice.
3. To facilitate recovery of all benefits paid toward your workers' compensation claim from any third party responsible for this injury.
4. To ensure that you are accurately compensated for any amount of lost wages, time or resources while undergoing evaluation, treatment and recovery for this injury.
5. To obtain any information necessary to appropriately determine further actions as a result of the injury or condition and to prevent further issues for you and other employees.

This consent and authorization is effective immediately, and is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate on conclusion of the claim without express revocation.

A copy or fax is as valid as the original.

(Names, addresses, and phone numbers of providers)

I have read this authorization and fully understand its entire contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received. I understand that I have a right to receive a copy of this authorization upon my request.

Signed: _____

Date: _____



Highview

A Muller Company

ADDITIONAL REFERENCES

FOR MORE INFORMATION,
VISIT:

WWW.NJ.GOV/LABOR/WORKERS/COMPENSATION/



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