Synergy Claims

Reducing Costs, Managing Claim Outcomes

The enclosed packet of forms must be completed for each work related injury. It is very important that all the forms are complete, signed and immediately returned.
Please provide as much detail as possible in your description.

Please fax or email these forms to:

856-964-3702 Attn: Tara Maguire, HR Department

tara.maguire@centerffs.org

Synergy Claims
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Centers for Family Services Inc

Employee Incident Report

OSHA Log # _____
Department # _____
Date of Hire _____

Employee Name: _____
Last First Middle Initial

Address: _____
Street City County State Zip Code

Phone Number: _____ Cell Number: _____

Email Address: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____ SS # _____

Number of Dependents: _____ Date of Hire: _____ Job Title: _____ Full or Part Time: _____

Personal Physician: _____ Phone Number: _____

Location of Incident: _____ Date Employer Notified of Incident: _____

Date of Incident: _____ Time of Incident: _____ AM / PM Time You Began Work: _____

Do you have other employment?: Yes _____ No _____ If yes: Full-time _____ Part-Time _____

If yes, name and address of employer: _____

_____

How did injury occur?: _____

_____

Identify all body parts affected & describe any pain or injury that you are presently experiencing: _____

_____

Have you ever had previous pain or injury to the body parts described above? Yes _____ No _____

If yes, please give details: _____

_____ I hereby ACCEPT to receive medical treatment. _____ I hereby DECLINE to receive medical treatment.

Were you seen by Physician? Yes _____ No _____ If Yes, Who? _____
When? _____ Where? _____

Was First Aid Administered? Yes _____ No _____ By Whom? _____
When? _____ Where? _____

Names of Anyone Who Witnessed Incident: _____

_____ _____
Signature of Injured Employee Date Witness Signature Date

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Synergy Claims Management Company
30 East State Street
Sharon, PA 16146
Phone: (724) 704-7060
Fax: (724) 704-7061

MEDICAL AND WORKERS' COMPENSATION CLAIM AUTHORIZATION

Insured: Centers for Family Services Inc

Injured Worker: _____

Date of Injury: _____

Date of Birth: _____

Social Security Number: _____

For purposes of and in conjunction with my worker's compensation, I hereby authorize and direct you to permit the bearer hereof, an authorized representative of Synergy Claims to inspect, examine, make, or be furnished with copies of **ALL** documents in connection with my illness, health, condition, injury, treatment, consultation, medical history, testing, surgery, emergency room and/or outpatient treatment, and confinement, including x-rays, and scanning studies and interpretive reports **regardless of the dates of service or purpose for treatment.**

I may later revoke this authorization by notifying an authorized representative of Synergy Claims in writing of my desire to revoke it. However, I understand that any action already taken in reliance upon this authorization cannot be reversed, and my revocation will not affect those actions.

I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that the information supplied may be subject to re-disclosure by the person or class of persons or facility receiving it, within the context of my worker's compensation, and would then no longer be protected by federal privacy regulations. Re-disclosure may include to a physician appointed by Synergy Claims or its authorized representative, to examine any x-rays or other films taken of me, or records regarding my physical condition and treatment.

_____ _____

Signature of Injured Worker or Authorized Representative *Date*

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Sharon, PA 16146
Phone: (724) 704-7060
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Normal Office Hours 8:30 a.m. to 5:00 p.m.

NOTICE TO NEW JERSEY EMPLOYERS AND EMPLOYEES

In accordance with the regulations adopted by the New Jersey Workers' Compensation Commission, insurance carriers are required to advise all policyholders and claimants of the following:

Any person who purposely or knowingly makes a false or misleading statement for the purpose of wrongfully obtaining benefits shall be guilty of a crime of the fourth degree.

If that person has received benefits to which the person is not entitled, he is liable to repay that sum plus simple interest to the employer or the carrier or have the sum plus simple interest deducted from future benefits payable to that person, and the division shall issue an order providing for the repayment or deduction.

The Division of Workers' Compensation may also order the immediate termination or denial of benefits with respect to that claim and a forfeiture of all rights of compensation or payments sought with respect to the claim.

By preventing fraud, the best interests of all parties are protected. Resources can then be properly devoted to legitimate claims, helping to ensure the speedy resolution of an injured employee's claim.

A message from the
Management Team of Synergy Claims Management Company

Signature of Employee: _____ **Date:** _____

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CPS Corporate Pharmacy Services

PriorityRx Prescription Payment Authorization Form

Please keep this Authorization Form on file with script for auditing purposes

Employee:

Please note: If your injury is determined to be work related, you may receive a permanent prescription card in the mail. Please contact CPS Customer Care at (866) 429-1116 if you have any questions.

Pharmacist:

This is a temporary workers' comp Rx payment authorization form. Please submit the prescription using the processing information listed below. Please contact CPS Customer Care at (866) 429-1116 if you have any questions.

Temporary Work Comp Prescription Card
PLAN limit: Max Day Supply is 5, Max $$ Amount is $250

Name: _____

Date of Birth: _____

ID/SSN: _____

Prior Authorization #: _____

PA# = Date of Injury in YYMMDD format (ex. July 20, 2014 would be 140720)

Processing Information:

Processor: EHO (Employer Health Options)
BIN#: NDC 004527
Envoy/WebMD 003241
CVS Condor Code 15721
Eckerd's/Rite Aid Condor Code 2185
Version: D.O
Group#: 70831 Questions? Call (866) 429-1116

By signing below, I acknowledge that I have been provided the temporary prescription card should a physician prescribe any medications

Print Name of Injured Employee	**Signature of Injured Employee**	**Date**

BILLING INFORMATION SHEET

For:

Centers for Family Services Inc

Workers' Compensation Claims

ALL MEDICAL BILLS MUST BE ON A UB92 OR HCFA 1500 FORM ACCOMPANIED WITH MEDICAL REPORTS AND SUBMITTED TO:

Synergy Claims
Reducing Costs, Managing Claim Outcomes

SYNERGY CLAIMS MANAGEMENT COMPANY

PO BOX 6310
Federal Street
Pittsburgh, PA 15212

Please CALL or FAX Synergy Claims Management Company With any questions regarding billing at:
Phone: (724) 704-7060
Fax: (724) 704-7061

Effective: 07/01/2020