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
Reducing Costs, Managing Claim Outcomes

INCIDENT REPORTING COVER SHEET

Please be sure to attach this cover letter to all Incidents that you are sending over to Synergy's Claims Department.

Do you have any concern regarding this incident? **Yes** ☐ **No** ☐

If yes, the space below has been provided for you to list any concerns or information that you want the Claim Manager to be aware of when beginning the investigation.

Does Employee have any pre-existing conditions or prior injuries that you are aware of? **Yes** ☐ **No** ☐

RED FLAGS/CONCERNS:

☐ Please indicate by checking this box if the employee who was involved in this incident speaks a language, other than English, as the primary language.

What language does the employee speak in his/her daily communication: _____

☐ Please check if medical treatment was sought by the injured employee, other than first aid

Please fax or email all forms: Attn: Tara Maguire, HR Department

Fax #: (856) 964-3702

Email (Updated): tara.maguire@centerffs.org

Synergy Claims
Reducing Costs, Managing Claim Outcomes

Supervisor Work Comp Checklist

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.

EMPLOYEE COMPLETES THE FOLLOWING:

- ☐ **Employee Incident Report:** must be signed by the injured employee for each work related injury. This provides a written signed statement from the employee.
- ☐ **Medical and Workers' Compensation Claim Authorization:** is a form that should be signed by employees for each work related injury. It prevents medical providers from delaying the release of medical records and documentation.
- ☐ **Fraud Notice:** This form documents that the employee has been advised of what constitutes fraud under the Workers' Compensation Act and what the penalties are.

The employee must take the following forms to the panel physician or pharmacy:

- ☐ **Pharmacy Letter:** notifies the panel pharmacy that the employee has reported a Workers' Compensation claim.
- ☐ **Billing Information:** notifies the provider with our billing information so the injured employee does not receive any bills.

SUPERVISOR COMPLETES THE FOLLOWING:

- ☐ **Supervisor Incident Investigation:** must be completed by the supervisor as soon as possible after the injury. It is critical that any fact discrepancies from the employee report be noted and documented.
- ☐ **Acknowledgement & Confirmation of Accident Repeater Policy:** must be completed by the supervisor and employee documenting employee's knowledge of the policy and addressing the appropriate corrective action.
- ☐ **Witness Statement:** must be completed by all witnesses (if any) as soon as possible after the injury.

Please fax or email these forms to:

(856) 964-3702 Attn: Tara Maguire, HR Department
tara.maguire@centerffs.org

Centers for Family Services Inc
Synergy Claims
Reducing Costs, Managing Claim Outcomes

WITNESS STATEMENT

Please answer each questions thoroughly and sign where indicated.

Name:_____

Address:_____
City State Zip Code

Phone: _____(cell)_____(home)_____

Employer: _____

Position: _____

Injured Worker: _____

Incident date: _____ Time: _____ Location:_____

Did you see the incident occur? Yes ☐ No ☐ Do you wear glasses or contacts? Yes ☐ No ☐

In your own words, please describe the events prior to, during, and immediately after the incident. If you need more space please use the back of this page.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please sign and date your statement of facts as you witnessed.

_____

Signature **Date**

Synergy Claims
Reducing Costs, Managing Claim Outcomes

SUPERVISOR INCIDENT INVESTIGATION FORM

Incident Date: _____ Incident Time _____

INJURED EMPLOYEE INFORMATION:

Name / Job Title _____

Type of Injury _____

DETAILS OF INCIDENT:

DEPARTMENT: _____ **LOCATION:** _____

Description of the Incident: **Recreate incident with Injured Employee**

_____

_____

_____

_____

Other persons who rendered assistance or witnessed the incident: **Complete Witness Statement**

_____

Supervisor's Investigation of Cause of the Incident: **Complete Root Cause Analysis Form**

_____

_____

_____

Corrective Action Recommended to Prevent Reoccurrence: Review with Injured Employee

1. _____ Person Responsible / Date _____
2. _____ Person Responsible / Date _____
3. _____ Person Responsible / Date _____

Employee Comments:

_____

_____

_____

Injured Employee Signature: _____ Date: _____

Department Supervisor's Signature: _____ Date: _____

Manager's Signature: _____ Date: _____

Centers for Family Services Inc

ACKNOWLEDGEMENT & CONFIRMATION

OF INCIDENT REPEATER POLICY IMPLEMENTATION

This form is to confirm that Centers for Family Services Inc has implemented and posted the Incident Repeater Policy. The purpose of the Incident Repeater program is to:

- Identify why Incidents are occurring and to implement remedial procedures
- It is intended to provide a mean of discussing Incidents with those who have been involved with several Incidents over a period of time.

***Agreement**: A discussion between management and the injured or affected employee has been completed to determine root cause and corrective action. Acceptable corrective actions are: counseling, redesigning job tasks and retraining.*

***Please print or type Corrective Action to be taken**:*

_____

_____

_____

_____

_____

_____ *(employee name), has been made aware of the Incident Repeater Policy & Program and agrees to implement and comply with said policy. By signing below I understand that I must perform my job with the highest level of personal safety awareness to stay* ***Incident free****.*

Injured Employee's Signature _____ ***Date*** _____

Management Signature _____ ***Date*** _____