IN CASE OF LIFE, LIMB OR SIGHT EMERGENCY CALL 911

FOR ALL OTHERS PLEASE CALL:

Must be done before seeking treatment

Nurse Triage Line
(855) 406-5111

Make sure that both injured employee and authorized supervisor are present for the call.

The Nurse Triage will assist you in determining the best action to take regarding the injury. If directed to seek medical treatment, the injured employee will be sent to the nearest approved occupational clinic. They will need to take the ***Medical Treatment Authorization*** that was completed by the authorized supervisor. Please make sure the injured employee gets a Work Status form from the doctor before leaving.

Preferred Provider

	Hours of Operation **Mon – Fri: 8:00am – 5:00pm**
	Emergency Treatment Only

PLEASE NOTE:

If you go to a medical provider not listed above, your employer or the insurance company may not pay the bill.

AND

No referrals to specialists are authorized unless approved by Method Claims Management.

EN CASO DE EMERGENCIA DE VIDA, MIEMBRO O VISIÓN LLAMADA 911

PARA TODOS LOS DEMÁS LLAME POR FAVOR:

Deve de ser llenado antes de obtener atension medica

Nurse Triage Line
(855) 406-5111

Asegúrese de que tanto el empleado lesionado como el supervisor autorizado están presentes para la llamada.

La enfermera lo asistira en determinar la mejor opsion respecto a su lesion de trabajo. Si es nesesario que tenga atension medica, el/la empleado (a) sera mandado a uno de los centros medico mas cercanos y aprovados por nuestro seguro. El supervisor authorizado nesesitara llenar la forma llamada ***Medical Treatment Authorization*** y el trabajador lastimado devera llevarla ala clinca. Por favor asegurese que el trabajador lastimado obtenga un Work Status (esta es la forma que especifica el estado del trabajador y si hay alguna restriction) de la clinica antes de salir.

Médico preferido

	Lunes - Viernes: **Mon – Fri: 8:00am – 5:00pm**
	Sólo para tratamiento de emergencia

FAVOR de NOTAR:

Si usted va a un proveedor médico no listó arriba, su empleador o la compañía aseguradora no puede ser capaz de pagar su factura médica.

Y

Ningunas referencias a especialistas médica son autorizadas a menos que aprobado por la Method Claims Management.

method

EMPLOYEE REPORT OF INJURY

Phone (888) 981-1702 **FAX to (972) 934-3091** **Email: nsclaims@methodinsurance.com**

*A complete First Notice of Loss must be submitted immediately

We also need a copy of your signature page from the Summary Plan Description and Arbitration Agreement

Please Print

EMPLOYER INFORMATION

Group Name MAC Pizza Management Group Policy Number NSL9318155-00

Supervisor/Manager Name _____ Supervisor/Manager Number _____

EMPLOYEE INFORMATION

Injured Employee Name _____ Soc. Sec. Num. _____ Date of Birth _____

Home Address (incl. city, state, zip) _____

Home Phone Number _____ E-mail Address _____

Employment Status

☐ Active ☐ Disabled ☐ Terminated Job Title/Description _____

Date Hired _____ Date Last Worked _____ Date Disibility Began _____

EMPLOYEE'S STATEMENT OF INJURY

Date of Accident _____ What time did the accident happen? (Specify am or pm) _____ Date of Report _____

When was the accident reported to Supervisor? _____ Name of Supervisor in charge at the time _____

Name of person filing report _____ WHERE did the accident occur (PHYSICAL ADDRESS) _____

What was the CAUSE of the accident? _____

What BODY PART(s) were injured? _____ What Type of Injury (ex.: Cut, Sprain, Fracture...) _____

Describe the DETAILS of the accident and how it happened. *Attach additional paper if necessary.*

_____

_____

_____

Did the injury require immediate emergency treatment? ☐ Yes ☐ No

Was offered medical attention but employee refused. ☐ Yes ☐ No

EMPLOYEE SIGNATURE _____

Date of 1st Medical Treatment _____

Treating physician and treating facility (name, address and phone number) _____

Have you ever been treated for this before? If yes, please explain. _____

Give full name, address and phone number of ALL other physicians consulted in the past three years.

_____

EMPLOYEE NAME (PRINT) _____ **DATE OF INJURY** _____

ACKNOWLEDGMENT

I ACKNOWLEDGE THAT MY EMPLOYER HAS A MANDATORY ARBITRATION AGREEMENT OR POLICY IN PLACE AT THIS TIME THAT COVERS MY INJURY CLAIM THAT I HAVE REPORTED AS OF THE DATE SHOWN BELOW. THAT AGREEMENT OR POLICY COVERS ANY CLAIMS I HAVE AGAINST MY EMPLOYER, ITS EMPLOYEES, AGENTS, OWNERS, PARENT ENTITIES, SUBSIDIARIES, DIVISIONS OR OTHER AFFILIATED OR RELATED INDIVIDUALS OR ENTITIES ARISING FROM ANY INJURY I INCUR IN THE COURSE AND SCOPE OF MY EMPLOYMENT (EXCEPT BENEFIT CLAIMS UNDER THE EMPLOYER'S BENEFIT PLAN AND CERTAIN CLAIMS THAT ARE NOT ARBITRABLE) AND PROVIDES THAT THOSE CLAIMS SHALL BE EXCLUSIVELY RESOLVED IN A BINDING ARBITRATION ADMINISTERED BY JUDICIAL WORKPLACE ARBITRATIONS. TO THE EXTENT I HAVE NOT BEEN PREVIOUSLY NOTIFIED OF THIS AGREEMENT OF POLICY, I UNDERSTAND AND AGREE THAT CONTINUING TO WORK FOR EMPLOYER AFTER RECEIVING THIS NOTICE OR ACCEPTING ANY BENEFITS UNDER MY EMPLOYER'S BENEFIT PLAN FOR INJURIES IN THE COURSE AND SCOPE OF MY EMPLOYMENT CONSTITUTES IRREVOCABLE ACCEPTANCE OF MY EMPLOYER'S ARBITRATION AGREEMENT OR POLICY.

EMPLOYEE SIGNATURE _____ **DATE** _____

RIGHT OF SUBROGATION AND REFUND

The injured employee may incur expenses due to injuries for which benefits are paid by the Injury Benefit Plan. If the injuries are caused by the wrongful act, omission or negligence of another person, the employee may have a claim against that other person for payment of the expenses. The Plan will be subrogated to all rights the employee may have against that other person and the employee must repay us out of the recovery made from: (a) the other person; or (b) the other person's insurer; or (c) any carrier providing uninsured or underinsured motorist coverage. The employee agrees to assist us in any recoveries and to not take any action that would prejudice our subrogation rights. The subrogation rights only apply to the amount of the Injury Benefit Plan paid because of that injury or death. Name and address of third party or other party involved: _____

EMPLOYEE SIGNATURE _____ **DATE** _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I certify that the information is true and correct to the best of my knowledge. I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, or other organization, institution or person that has any records or knowledge of me or my health to give to my Occupational Injury Benefit Plan Administrator, Method Claims Management, their legal representative, or designees any such information. Such release may include information that may be considered a communicable and/or venereal disease, hepatitis, HIV related, AIDS, AIDS related disorders, mental/nervous disorders, drug abuse and/or alcoholism. I understand the information obtained using this Authorization will be used by my Occupational Injury Benefit Plan Administrator or Method Claims Management to determine eligibility for benefits under the Group Policy. Any Information will not be released to any person or organization except insurance companies, or any other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

A photocopy of this Authorization shall be as valid as the original.

I understand that I am entitled to a copy of this Authorization.

EMPLOYEE SIGNATURE _____ **DATE** _____

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

MEDICAL TREATMENT AUTHORIZATION

GIVE THIS TO THE INJURED EMPLOYEE TO SHOW THE DOCTOR & PHARMACIST.

You need to send a copy to us by fax (972) 934-3091 or by email at nsclaims@methodinsurance.com

Injured Employee:
On your first visit, please give this form to any pharmacy listed to speed up the processing of your approved work-related injury prescriptions (based on the guidelines established by your employer). If you have questions or need assistance locating a participating retail network pharmacy, call the MyMatrixx Patient Care Contact Center at 800.945.5951.

Atencion Trabajador Lesionado:
En su primera visita, entregue este formulario a cualquier farmacia que se encuentre en el reverso del boleto para acelerar el procesamiento de sus recetas aprobadas para lesiones relacionadas con el trabajo (según las reglas establecidas por su empleador). ¿Tiene preguntas o necesita ayuda para localizar una farmacia participante? Llame al centro de contacto para pacientes de MyMatrixx al 800.945.5951.

Policyholder: MAC Pizza Management

Policy #: NSL9318155-00

Employee Name *: _____
(nombre completo)

Date of Injury*: _____
(fecha de la lesion)

Employee SS#*: _____
(Numbero de Seguro social del empleado)

Date of Birth*: _____
(fecha de Nacimiento)

Home Address (Street, City, ST, Zip)*: _____
(direccion de casa)

Description of Injury for Treatment (include affected body parts): _____

_____

_____

Required (Requerido)

Drug/Alcohol Screen Required: ☐ YES ☑ NO

Please conduct a drug/alcohol screen for your panel of controlled substances and alcohol, in addition to treating the reported work injury. The results of the drug/alcohol screen must be reported only to the Employer and/or Method Claims Management.

Dear Medical Provider:

This injured worker is covered under an Occupational Accident Policy administered by Method Claims Management. The employer is committed to providing modified duty within the restrictions you define. A work status form with any restrictions and the next scheduled appointment is required. Please contact Method Claims Management to verify coverage and pre-certify services:

Call (888) 981-1702 or Fax (972) 934-3091

Dear Pharmacy Provider:

MyMatrixx administers this Texas Non-Subscriber prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 30-day supply or a cost of $300. This form is valid for up to 30 days from the date of injury (DOI). Limitations may vary.

For assistance, please call MyMatrixx at (888) 786-9640.

Processing Steps:

1. Enter **RxBin** 003858
2. Enter **PCN** WC
3. Enter **Rx Group Number** 77FA
4. Enter **ID#** Claimant 9-digit SSN
5. Enter **Date of Injury** MM/DD/YYYY

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

MyMatrixx – Participating Pharmacy List

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

H-E-B

CVS

Walgreens

Wal-Mart

Sam's Club

Brookshire Brothers

United Supermarket

Costco Wholesale

Target

For assistance, please call MyMatrixx at (888) 786-9640

1. **Enter RxBin: 003858**
2. **Enter PCN WC**
3. **Enter Rx Group Number 77FA**
4. **Enter ID #: Your 9-digit SSN**
5. **Enter Date of Injury (MM/DD/YYYY)**