SOUTHERN MUTUAL CHURCH INSURANCE COMPANY
201 Greenlawn Drive ▪ P.O. Box 9346 ▪ Columbia, SC 29290-0346 ▪ 1-800-922-5332 ▪ 803-776-9365 ▪ 803-776-4260 FAX

Planned Administrator's Inc. (PAI) will manage your Workers' Compensation claims on behalf of Southern Mutual Church Insurance Company. This packet contains all the information needed to report your Workers' Compensation losses. Please take a moment to review this material and contact us with any questions you have. You may report injuries by mail, fax, email or phone.

PLEASE REPORT ALL CLAIMS TO THE FOLLOWING:

Mailing Address:	**Planned Administrator's Inc.** **Post Office Box 100159, Columbia, SC 29202**
Phone Number:	**1 (800) 827-5794 Option #3**
Fax Number:	**1 (844) 230-8259**
Claims Reporting Email:	**tpaclaims@companiontpa.com**

When reporting a claim by phone, you will be asked questions similar to those on the First Report of Injury form (see below). The more information you have on hand the less time the call will take and the less need for follow-up. Phone reports generally take approximately 10 minutes.

-Tax ID Number
-Policy Number
-When/where/how injury occurred
-Type of injury (cut, burn, etc.)
-Name of exact part of body injured
-Name and address of injured person
-Social Security Number
-Age, sex, and marital status
-Wage information
-Anticipated return to work date
-Name and address of physician
-Name of witnesses
-Date of hire and year on current job
-Number of dependents

We are excited about the opportunity to partner with you and believe that you will find us to be a valuable tool in the overall management of your insurance programs. As always we welcome the opportunity to answer any questions you may have about the contents of this packet or Workers' Compensation in general.

Welcome to Planned Administrator's Inc.!

Enclosed is a copy of your Claims Packet. We hope this information will be useful to you. Included in this packet is the following information:

- Contact Information for your PAI team members
- NC FORM 19 EMPLOYER'S REPORT OF EMPLOYEE'S INJURY Complete this form immediately upon notice of an accident with as much information as possible. The form should be immediately mailed, faxed or emailed to Planned Administrator's Inc. You should complete the form any time a work related injury is reported to you even if you feel the employee is not entitled to benefits. We will investigate the claim and defend you accordingly. *Planned Administrator's Inc. mailing address, fax number, and email address are listed on the next page.*
- NC FORM 18 EMPLOYEE'S FIRST REPORT OF INJURY Complete this form immediately upon notice of an accident with as much information as possible. The form should be immediately mailed, faxed or emailed to Planned Administrator's Inc. You should complete the form any time a work related injury is reported to you. *Planned Administrator's Inc. mailing address, fax number, and email address are listed on the next page.*
- Claims Reporting Instructions
- Pharmacy Information from our preferred pharmacy vendor, Corporate Pharmacy Services.
- Useful reference links

We look forward to working with you as a member of your Risk Management team.

Workers' Compensation Contact Information

Mailing Address: Planned Administrator's Inc.
17 Technology Circle, Suite E2AG, Columbia, SC 29203
Post Office Box 100159, Columbia, SC 29202

Phone Number: 1 (800) 827-5794 Option # 3

Fax Number: 1 (844) 230-8259

Claims Reporting Email: tpaclaims@companiontpa.com

PAI Claims Team

Jonathan Duarte
Senior Claims Adjuster

Direct Dial: (803) 264-4492
Toll-Free #: (800) 827-5794 ext. 44492
Fax #: (844) 230-8259
E-Mail: jonathan.duarte@companiontpa.com

Sherry Branham
Medical Only Assistant

Direct Dial: (803) 264-6260
Toll Free #: (800) 827-5794 ext. 46260
Fax #: (844) 230-8259
E-Mail: sherry.branham@companiontpa.com

Linda McCallister
Claims Supervisor

Direct Dial: (803) 264-0423
Toll Free #: (800) 827-5794 ext. 40423
Fax #: (844) 230-8259
E-Mail: linda.mccallister@companiontpa.com

North Carolina Industrial Commission

IC File #_____

Emp. Code #_____

Carrier Code #_____

Employer FEIN_____

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

NOTICE OF ACCIDENT TO EMPLOYER AND CLAIM OF EMPLOYEE, REPRESENTATIVE, OR DEPENDENT (G.S. §§97-22 THROUGH 24)

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employee's Name	Employer's Name ( ) - Telephone Number
Address	Employer's Address City State Zip
City State Zip	SOUTHERN MUTUAL CHURCH INSURANCE CO. Insurance Carrier Policy Number
( ) - Home Telephone	( ) - Work Telephone
PLANNED ADMINISTRATOR'S INC. PO BOX 100159 COLUMBIA SC 29202 Carrier's Address City State Zip	
- - Social Security Number	☐ M ☐ F Sex / / Date of Birth
(803) 827-5794 Carrier's Telephone Number	(844) 230-8259 Carrier's Fax Number

EMPLOYEE – This form must be filed with the Industrial Commission within two years of the date of injury or occupational disease or your claim may be barred. Notice shall be given to the employer immediately after the accident or as soon as practicable and within 30 days. (This form should also be used for occupational disease claims; however, for asbestosis, silicosis and byssinosis, Form 18B is to be used.)

Notice is hereby given, as required by law, that the above-named employee sustained an injury or contracted an occupational disease, described as follows: _____ (Time of Injury) on ____/__/____ (Date (required)) at _____ (City and County). Describe the injury or occupational disease, including the specific body part involved (e.g., right hand, left hand) _____

Describe how the injury or occupational disease occurred: _____

Occupation when injured: _____ Nature of employer's business: _____

Number of days out of work due to injury:

Medical treatment received? ☐Yes ☐No

Weekly wage: $_____ Number of hours worked per day: _____ Days worked per week: _____

NOTE: If employee is unable to sign this form, another may sign for him. This form should be typed or printed by hand in black ink, if possible. Employee should retain one signed copy of this notice, mail one signed copy to the Industrial Commission at the address below, and provide one signed copy to employer.

_____ ( ) - _____

Signature of (Check One) ☐ Employee, ☐ Attorney, ☐ Representative, or ☐ Dependent — Telephone Number

_____ / /

Address City State Zip — Date Completed

EMPLOYER: This notice is being sent to you in compliance with requirements of the North Carolina Workers' Compensation Act, in order that the medical services prescribed by the Act may be obtained; and, if disability extends beyond 7 days duration, or if death ensues, compensation may be paid according to law.

FOR IC USE ONLY

RESEARCHER: _____
CC: _____
EC: _____
DATA ENTRY: _____

FORM 18

MAIL TO:

NCIC - CLAIMS ADMINISTRATION
1235 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1235
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

GENERAL INFORMATION ON THE FORM 18

1. What does a Form 18 do?

A Form 18 establishes a legal claim of injury on your behalf if filed within two years of the date of injury or occupational disease, and gives the required written notice to the employer if a copy is submitted to the employer within 30 days of the injury. The employer is required by law to file a Form 19 if the employee misses more than one day of work due to the injury or if the medical bills exceed $2,000.00. However, the employer's filing of a Form 19 does not satisfy the employee's obligation to file a claim. In order to ensure the employee's rights are protected, the employee must file a Form 18 even though the employer may be paying compensation or the Industrial Commission may have opened a file for the injury.

2. To whom should the Form 18 be sent?

The original Form 18 should be submitted to the Industrial Commission. The injured worker should keep one copy for his or her records and one copy should be submitted to the employer at the time of the injury.

3. What numbers do I write in the upper right corner?

You do not need to fill in the spaces on the upper right corner of the Form 18. If you know that your employer has already filed a report of injury, (Form 19) and you know what your I.C. (Industrial Commission), File Number is, you may write the number in the "I.C. File No." space. If you do not already have an I.C. File Number, the Industrial Commission will assign one upon receipt of the Form 18. The other three spaces, "Emp. Code No.," "Carrier Code No.," and "Employer FEIN" are for internal use only.

4. What if I do not know who my employer's insurance carrier is?

If you do not know who the employer's insurance carrier is you may either ask your employer for the information, call the Industrial Commission's Claims Administration Section at (800) 688-8349 then press "1" after the prompt, or simply leave the line blank.

5. When listing the number of days out of work, do I count partial days?

Yes, you include partial as well as whole calendar days not worked. However, the days do not need to be consecutive.

6. What happens after I file the Form 18?

The Industrial Commission will mail an acknowledgement letter to you after your Form 18 is processed. Processing time varies according to current workload. The Industrial Commission will mail a copy of the acknowledgement letter to the employer or its workers' compensation insurance carrier asking them to contact you and inform you if compensation will be paid to you voluntarily.

North Carolina Industrial Commission

IC File #_____

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

Emp. FEIN_____

Carrier FEIN_____

Carrier File #_____

To the Employer:
A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law.
This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

To the Employee:
This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed **Form 18** and mail it to Claims Administration, N.C. Industrial Commission, 4335 Mail Service Center, Raleigh, NC 27699-4335 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Employee's Name		Employer's Name	( ) - Telephone Number
Address		Employer's Address	City State Zip
City	State Zip	SOUTHERN MUTUAL CHURCH INSURANCE CO. Insurance Carrier	Policy Number
( ) - Home Telephone	( ) - Work Telephone	PLANNED ADMINISTRATOR'S INC PO BOX 100159 COLUMBIA SC 29202 Carrier's Address	City State Zip
- - Social Security Number	☐ M ☐ F Sex / / Date of Birth	(800)827-5794 Carrier's Telephone Number	(844)230-8259 Fax Number

Employer	1.	Give nature of employer's business
Time And Place	2.	Location of plant where injury occurred County Department State if employer's premises
	3.	Date of injury / / 4. Day of week Hour of day : ☐ A.M. ☐ P.M.
	5.	Was employee paid for entire day 6. Date disability began / / ☐ A.M. ☐ P.M.
	7.	Date you or the supervisor first knew of injury / / 8. Name of supervisor
Person Injured	9.	Occupation when injured
	10.	(a) Time employed by you (b) Wages per hour $
	11.	(a) No. hours worked per day (b) Wages per day $ (c) No. of days worked per week (d) Avg. weekly wages w/ overtime $ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. $ per
Cause And Nature Of Injury	12.	Describe fully how injury occurred and what employee was doing when injured: (Statement made without prejudice and without vouching for correctness of information)
	13.	List all injuries and specify body part involved (e.g. right hand or left hand):
	14.	Date & hour returned to work / / at : .M. 15. If so, at what wages $ per
	16.	At what occupation 17. Employee's salary continued in full?
	18.	Was employee treated by a physician
Fatal Cases	19.	Has injured employee died 20. If so, give date of death (Submit Form 29) / /

Employer name _____ Date Completed / /

Signed by _____ Official Title _____

OSHA 301 Information:

Case Number from Log:	Date Hired: / /	Time Employee began work on date of incident: : ☐ A.M. ☐ P.M.	If off-site medical treatment provided, answer entire next line.
Name of facility:		Address: Street/City/Zip/Telephone	ER visit? ☐ Yes ☐ No / Overnight stay? ☐ Yes ☐ No

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

FOR IC USE ONLY
RESEARCHER:_____
CC:_____
EC:_____
DATA ENTRY:_____

FORM 19

SELF-INSURED EMPLOYER OR CARRIER, FILE AS **FROI** VIA **EDI**: **HTTP://WWW.IC.NC.GOV/EDIFORM19.HTML**

UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:
E-MAIL TO: FORMS@IC.NC.GOV OR MAIL TO: NCIC - CLAIMS SECTION, 1235 MAIL SERVICE CENTER, RALEIGH, NC 27699-1235
MAIN TELEPHONE: (919) 807-2500 HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

IMPORTANT INFORMATION FOR EMPLOYER

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This Form 19 must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident. Employer must also give employee a blank Form 18.

IMPORTANT INFORMATION FOR EMPLOYEE

Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON
ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS

Reporte de una Lesión (Reporting an Injury)

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un período de treinta (30) días a partir de la fecha de la lesión.

Cómo Presentar una Reclamación (Making a Claim)

Para ceriorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un período de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED PUEDE HABLAR AL (800) 688-8349

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA
EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN *[I.C. FILE NUMBER]* (SI LO SABE)
O SU NÚMERO DE SEGURO SOCIAL.

FORM 19

SELF-INSURED EMPLOYER OR CARRIER, FILE AS **FROI** VIA **EDI:**
HTTP://WWW.IC.NC.GOV/EDIFORM19.HTML

UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:
E-MAIL TO: **FORMS@IC.NC.GOV** OR MAIL TO: **NCIC - CLAIMS SECTION, 1235 MAIL SERVICE CENTER, RALEIGH, NC 27699-1235**
MAIN TELEPHONE: **(919) 807-2500** HELPLINE: **(800) 688-8349**
WEBSITE: **HTTP://WWW.IC.NC.GOV/**

Clients

How to submit a First Report of Injury to

E-MAIL

tpaclaims@companiontpa.com

FAX

1-844-230-8259

PHONE

1-800-827-5794 Option #3

SNAIL MAIL

Planned Administrator's Inc.
P.O. Box 100159
Columbia, SC 29202

Pharmacy Program

In conjunction with

PRESCRIPTION PROCESS

- Complete the attached workers compensation prescription authorization form.
- Upon completion of the form ask the injured employee which pharmacy they would like to use and obtain the pharmacy phone number.
- Call the pharmacy to obtain their fax number or e-mail address.
- Fax or e-mail the authorization sheet to the selected pharmacy.
- The patient is loaded by the pharmacy.
- The authorization form will allow the injured employee to obtain prescriptions immediately for the first set of prescriptions only. The prescription authorization will be extended once the claim is received in Planned Administrator's Inc.
- The authorization may be extended or revoked by contacting CPS at (866) 429-1116.
- Network pharmacies can be found using a zip code search by going to www.corporatepharmacy.com and clicking on pharmacy locator.

SOUTHERN MUTUAL CHURCH INSURANCE COMPANY
WORKERS' COMPENSATION
PRESCRIPTION PAYMENT AUTHORIZATION FORM

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

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.

To transmit a prescription claim, please use the following information:

Processing information

Processor: EHO (Employer Health Options)
Bin #'s: NDC = 004527 (most pharmacies use this number)
Envoy/WebMD = 003241
CVS Condor Code = 15721
Walgreen's Bin # = ehowc
Eckerd's/Rite Aid Condor Code = 2185

(These specific pharmacy chains require special numbers to transmit prescriptions. All major chains and most independent pharmacies accept this plan.)

Version: D.O

Patient Information

Last Name: _____

First Name: _____

Group#: 70065 **Sex: Male [ ] Female [ ]**

ID# / SS#: _____

D.O.B.: _ _ / _ _ / _ _ _ _

Prior Authorization #: _____ **(retain this # for future use)**

Date Sent: _____

Mail Order Program

Program Features

- Below state fee schedule pricing
- Pricing based on cost plus basis (averages 25%-30% below fee schedule pricing)
- 90 day supply of non-narcotic medications
- Prescriptions automatically filled with generics
- Generates savings and management reports
- Offers recommendations based on reports
- Prescriptions delivered directly to injured workers' home
- Adult signature required on narcotic packages
- In-house tracking capabilities of all packages shipped via Federal Express
- Toll free patient and physician phone numbers
- Screen medication for compensability to injury, early refills, duplicated drug therapy, etc.

Useful Reference Links

North Carolina Industrial Commission
http://www.ic.nc.gov/

Center for Disease Control & Prevention (CDC):
www.cdc.gov

National Safety Council (NSC)
www.nsc.org

U.S. Department of Transportation
www.dot.gov

American Industrial Hygiene Association
www.seinet.org