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
- GA FORM WC1 (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 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.*
- GA FORM WC6 (Wage Statement) Complete this form for all claims other than minor medical cases. The Instructions are on the form. This form along with Form WC1 should be immediately mailed, faxed or emailed to Planned Administrator's Inc. *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
- A reference list of useful internet 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

WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	❑ Male ❑ Female	Birthdate	Phone Number	Employee E-mail
Address		City	State	Zip Code
EMPLOYER	Name	NAICS Code	Nature of Business (Trade, Transport, Mfg.,etc.)	
Address		Phone Number	Employer FEIN	
City	State	Zip Code	Employer E-mail	
INSURER / SELF-INSURER	Name: SOUTHERN MUTUAL CHURCH INSURANCE CO.	Insurer/Self-Insurer FEIN	Insurer/ Self-Insurer File #	
CLAIMS OFFICE	Name: PLANNED ADMINISTRATOR'S INC.	Claims Office FEIN #	Claims Office Phone: 1-800-827-5794	Claims Office E-mail: TPACLAIMS@COMPANIONTPA.COM
SBWC ID# (five digit no.)	Address: PO BOX 100159	City: COLUMBIA	State: SC	Zip Code: 29202

EMPLOYMENT/WAGE	Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease: ❑ per Hour ❑ per Day ❑ per Week ❑ per Month
Insurer Type Code ❑I – Insurer ❑S-Self-insurer ❑Group Fund	List Normally Scheduled Days Off			

INJURY/ILLNESS & MEDICAL	Time of Injury ❑ am ❑ pm	County of Injury	Date Employer had knowledge of Injury	Enter First Date Employee Failed to Work a Full Day
Did Employee Receive Full Pay on Date of Injury? ❑ Yes ❑ No	Did Injury/Illness Occur on Employer's premises? ❑ Yes ❑ No	Type of Injury/Illness	Body Part Affected	
How Injury or Illness / Abnormal Health Condition Occurred				
Treating Physician (Name and Address)	Initial Treatment Given: ❑ None ❑ Minor: By Employer ❑ Minor: Clinical/Hospital ❑ Emergency Room ❑ Hospitalized > 24hrs	Hospital / Treating Facility (Name and Address)	If Returned to Work, Give Date: / Returned at what wage per Week / If Fatal, Enter Complete Date of Death	

Report Prepared By (Print or Type)	Telephone Number	Date of Report

❑ B. INCOME BENEFITS **Form WC-6 must be filed if weekly benefit is less than maximum**

Previously Medical Only ❑ Yes ❑ No

Average Weekly Wage: $ _____ Weekly benefit: $ _____ Date of disability:

Date of first Payment: _____ Compensation paid: $ _____ or Date salary paid: _____ Penalty paid: $ _____

BENEFITS ARE PAYABLE FROM _____ FOR:

❑ Temporary total disability ❑ Temporary partial disability ❑ Permanent partial disability of _____ % to _____ for _____ weeks.

UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.

❑ C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

❑ D. MEDICAL ONLY INJURY **(No indemnity benefits are due and/or have NOT been controverted.)**

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	Date
Phone Number	E-mail	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.

2. Complete Section A of this form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY**.
   Do not send this form to the State Board of Workers' Compensation.

3. If you need additional help, call your insurance company or self-insurer claims office.

4. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

NOTICE TO INSURER / SELF-INSURER

1. Complete Section B, C, or D.
   This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form must be sent to the claimant(s) and all counsel of record. Section B: completed when indemnity benefits are paid. Section C: completed when claim is controverted. Section D: completed when no indemnity benefits are due and/or have NOT been controverted. Form W-6 must be filed if weekly benefits are less than the maximum.

NOTICE TO EMPLOYEE

1. This form is provided for your information only.

   If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

   If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a form WC-14, Notice of Claim, within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

   If Section D is completed, you will receive medical benefits only. At this time, indemnity benefits are not due. If your medical bills are not paid, call your employer or your employer's insurance company or self-insured claims office.

For Information or Assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free Telephone: 1-800-533-0682
In Atlanta: (404) 656-3818

http://www.sbwc.georgia.gov

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

WAGE STATEMENT

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Address		
E-mail Address		City	State	Zip Code
EMPLOYER	Name	Address		
E-mail Address		City	State	Zip Code
INSURER/ SELF-INSURER	Name: SOUTHERN MUTUAL CHURCH INSURANCE CO.	SBWC ID# (five digit number)		
CLAIMS OFFICE	Name: PLANNED ADMINISTRATOR'S INC.	Claims Office Address: PO BOX 100159		
E-mail Address: TPACLAIMS@COMPANIONTPA.COM	Insurer/Self-Insurer File #	City: COLUMBIA	State: SC	Zip Code: 29202

B. COMPUTATION OF AVERAGE WEEKLY WAGE

If the weekly benefit is less than the maximum, complete the schedule below for thirteen (13) weeks immediately preceding the accident. If the employee has not been in your employ for the thirteen (13) weeks, complete this schedule showing gross weekly earnings of a similar employee in the same employment. If either of the foregoing methods cannot be reasonably and fairly applied, the full time weekly wage of the injured employee should be used.

❑ 13 Weeks of Employee's Wages ❑ 13 Weeks of a Similar Employee's Wages ❑ Full Time Weekly Wage of Injured Employee: $_____

SCHEDULE OF WEEKLY EARNINGS

Week	From Date MM/DD/YYYY	To Date MM/DD/YYYY	No. of Days Worked	Gross Amount Paid Including Overtime or Extra Work	Value of Additional Compensation					Total Earnings
					Meals	Lodging	Rent	Tips	Other	
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
			Total							
			Average Weekly Earnings							

C. SCHEDULED DAYS OFF

REQUIRED TO COMPLETE: ❑ Mon ❑ Tue ❑ Wed ❑ Thur ❑ Fri ❑ Sat ❑ Sun ❑ No Off Days

D. REMARKS

REMARKS:

Type or Print Name	Signature	Date
E-mail Address	Phone Number	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

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 by 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

State Board of Workers' Compensation
https://sbwc.georgia.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