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
- KY FIRST REPORT OF INJURY FORM 12A 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.*
- 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

IA-1 WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General

Employer (Name & Address incl. zip)

Carrier/Administrator Claim Number | Report Purpose Code

Jurisdiction | Jurisdiction Claim Number

Insured Report Number

Employer's Location Address (if different) | Location No.

Sic Code | Employer FEIN | Phone No.

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)
SOUTHERN MUTUAL CHURCH INSURANCE CO.
PO BOX 9346
COLUMBIA SC 29290-0346

1-800-922-5332

Policy Period
To
☐ Check if self insured

Claims Admin (Name, Address & Phone Number)

PLANNED ADMINSTRATOR'S INC.
PO BOX 100159
COLUMBIA SC 29202
PHONE: 1-800-827-5794 OPTION #3
FAX: 1-844-230-8259
EMAIL: TPACLAIMS@COMPANIONTPA.COM

Carrier FEIN | Policy Number or Self-Insured Number | Administrator FEIN

Agent Name & Code Number

Employee/Wage

Legal Name (Last, First, Middle) | Date of Birth | Social Security Number | Date Hired | State of Hire

Address (Incl. Zip)

Sex: ☐ Male ☐ Female ☐ Unknown

Marital Status: ☐ Unmarried/ Single/Div. ☐ Married ☐ Separated ☐ Unknown

Occupation/Job Title

Employment Status

Phone | No. of Dependents | NCCI Class Code

Wage Rate $ ☐ Day ☐ Week ☐ Month ☐ Other

Days Worked/WK | # Hrs Worked per Day

Full Pay for Date of Injury? ☐ Yes ☐ No

Did Salary Continue? ☐ Yes ☐ No

Occurrence

Time Employee Began Work ☐ AM ☐ PM | Date of Injury or Illness | Time Occurred ☐ AM ☐ PM | Last Work Date | Date Employer Notified | Date Disability Began

Employer Contact Name/Phone Number | Type of Illness/Injury | Part of Body Affected

Did Injury/Illness Exposure Occur on Employer's Premises? ☐ Yes ☐ No | Type of Illness/Injury Code | Part of Body Affected Code

Department or location where accident or illness exposure occurred

All Equipment, Materials, or Chemicals Employee was using when accident or illness exposure occurred.

Specific Activity the Employee was engaged in when the accident or illness exposure occurred.

Work Process the Employee Was Engaged in when accident or illness exposure occurred.

How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill. | Cause of Injury Code

Date Returned to Work | If Fatal, Date of Death

Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No

Were they used? ☐ Yes ☐ No

Treatment

Physician/Health Care Provider (Name & Address)

Hospital (Name & Address)

Initial Treatment
0 ☐ No Medical Treatment
1 ☐ Minor: By Employer
2 ☐ Minor Clinic/Hosp
3 ☐ Emergency Care
4 ☐ Hospitalized > 24 hr.
5 ☐ Future Major Medical/Lost Time Anticipated

Other

Witness to Accident (Name & Phone Number)

Date Administrator Notified | Date Prepared | Preparer's Name & Title | Preparer's Phone Number

IA-1 (2/95)

SEE NEXT PAGE FOR IMPORTANT STATE INFORMATION/SIGNATURE

Applicable in Alaska

A person who willfully makes a false or misleading statement or representation for the purpose of obtaining or denying a benefit or payment is guilty of theft by deception.

Applicable in Arkansas

Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully decreasing any claim for benefit or payment or obtaining or avoiding worker's compensation coverage or avoiding payment of the proper insurance premium (or who aids and abets for either said purpose), under this chapter shall be guilty of a Class D. felony.

Applicable in California

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Applicable in Connecticut

This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Applicable in Delaware and Oklahoma

Any person who, knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. The lack of such a statement shall not constitute a defense against prosecution under this section. *Delaware Statutes Regulation: Del #C Section 913(B)

Applicable in Florida

Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files any statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Applicable in Idaho

Any person who Knowingly and with the intent to injure, Defraud, or Deceive any Insurance Company, Files a Statement of Claim Containing any False, Incomplete or Misleading information is Guilty of a Felony.

Applicable in Indiana

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Kentucky and New York

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In New York, such person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in Michigan

Any person who knowingly and with intent to injure or defraud any insurer submits a claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to $5,000.00.

Applicable in Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Applicable in New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in Ohio

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Pennsylvania

Any person who knowingly and with intent to injure or defraud any insurer files a claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years or payment of a fine of up to $50,000.

Applicable in Utah

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

EMPLOYEE SIGNATURE: _____

IA-1 (2-95)

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

Kentucky Department of Workers' Compensation
http://www.labor.ky.gov/workersclaims/Pages/Department-of-Workers'-Claims.aspx

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