MMMA | SELF-INSURED WORKERS' COMPENSATION FUND

Claims Guide

Dear {{employer}}

Missouri Merchants and Manufacturers Association's Self-Insured Workers' Compensation Fund (MMMA SIWCF) welcomes you back for another year of partnership. Our vision is to provide innovative solutions for managing and controlling workers' compensation exposures while advocating timely, quality care for injured workers and managing your costs. We promise to continue to exceed your expectations through professional, responsive and proactive service.

In these pages, you will find the resources you need to take full advantage of the services that MMMA provides to you, and your employees. We encourage you to read this information thoroughly to be prepared for workers' compensation exposures.

If you have questions about MMMA's SIWCF or any of the information provided, please contact us at 636.537.4613 or www.claimsmgmtmo.com for assistance.

We look forward to providing you outstanding service and support, and a continued partnership in the years to come.

Sincerely,

Tim Phelps
President
636-681-5281
tphelps@mmm-a.com

Third Party Administrative (TPA) services provided by Claims Management of MO, LLC

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Fax: 636-537-1362

Website: www.mmm-a.com

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MMMA – Claims Management of Missouri, LLC
15450 South Outer 40 Road
Suite 200
Chesterfield, MO 63017-4817

Bill Petroshak
Loss Control Specialist
Compliance Coordinators, Inc.
bpetroshak@gmail.com
816-215-9825

Report a New Claim 24/7

Call NurseNow 1-855-704-3555

*MMMA SIWCF - TPA Services provided by Claims Management of Missouri, LLC

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Medical Only Claims <$1,000-$3,200 Notification

Under Section 287.957 RSMo, the employer may pay up to $1000 prior to 9/1/16 and up to $3200 after 9/1/16 for out-of-pocket for injury related medical costs only if there is no lost time greater than 3 days and no claim for compensation is filed by the employee.

**** PLEASE NOTE: Employers have a statutory obligation to report "all" claims regardless of cost or severity.**

MMMA processes all medical bills in-house. To take advantage of removing the <$1,000-$3,200 medical only claims from the members' experience modification rating, members who choose to do so can reimburse MMMA for the bills associated with these claims.

Members will be given the option to reimburse MMMA for their qualifying closed, medical only claims on a quarterly basis. As indicated above, if you choose to reimburse these qualifying claims, the claim(s) dollars will be reduced to $0.00. Any claim with a balance of $0.00 will not affect your experience modification rating.

ALL accidents/incidents are to be reported to MMMA with a First Report of Injury. Reporting a new claim via the NurseNow Hotline is the preferred method, but we also accept claims by Internet, fax or e-mail.

Advantages:

1. All claims are reviewed for compensability under work comp
2. All invoices are reviewed for appropriateness of care
3. All payments are discounted by MCO and direct discount reductions
4. All payments are made in a timely manner
5. All medical records received will be reviewed
6. All claims are reported to the Centers for Medicare & Medicaid Services (CMS) – per the Medicare Secondary Payer (MSP) Section 111- SCHIP Extension Act

Employer's Responsibility:

"Employers shall……report all injuries to their insurance carrier, or Third Party Administrators (IE: MMMA-Claims Management of MO) within five (5) days of the date of injury or within five (5) days of the date in which the injury was reported to the employer by the employee, whichever is later."

MMMA's Responsibility:

It is the responsibility of MMMA to file the First Report of Injury with the Division of Workers' Compensation.

Possible Consequences For Not Reporting Claims:

1. Fines levied by the Division of Workers' Compensation for late filing or incomplete reporting of the First Report of Injury.
2. Increased exposures on claims – Claims that are not reported to MMMA will extend the statute of limitations from 2 years of injury or death or last medical payment – to 3 years of injury or death or last medical payment. For example, an employee has a minor finger cut in which the employer does not report to MMMA. Since this claim was not reported to MMMA and/or the State of Missouri; now the employee has 3 years to retain an attorney and/or file a Form 21 to pursue a Permanent Partial Disability (PPD) settlement.
3. Penalties and fines can be levied by Centers for Medicare & Medicaid Services. We are currently reporting all claims, as required by the Medicare Secondary Payer (MSP) Section 111- SCHIP Extension Act, on behalf of MMMA Fund Members. If claims are not reported to us in a timely manner, we will not be able to file with Medicare on your behalf.
4. Increased exposure to your Company and MMMA Fund Members for claims incurred but not reported (IBNR), which is calculated on the financial statement for MMMA-SIWCF.

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How to Report a Claim Checklist

Step 1: Assess the Situation

- ☐ If emergency medical treatment is needed: **CALL 911**

Step 2: Report the Claim

- ☐ Call our 24/7 NurseNow Hotline to report a new claim: **1-855-704-3555**
  The nurse will submit the First Report of Injury to MMMA on your behalf.

Step 3: Complete Forms

Supervisor/Witness Forms

- ☐ **Form #1** Supervisor Incident Report
- ☐ **Form #2** Obtain Witnesses Names and complete Witness Statements

Employee Forms

- ☐ **Form #3** Employee Incident Report
- ☐ **Form #4** Employee Pain Chart
- ☐ **Form #5** HIPAA Medical Authorization
- ☐ **Form #6** Provide Employee First Fill Temporary Pharmacy Card for prescriptions

Employer/Risk Manager Forms

- ☐ **Form #7** Wage Statement (13 weeks prior to date of injury) if requested
- ☐ **Form #8** Light Duty Offer (confirm availability with employee)
- ☐ **Form #9** Drug/Alcohol Violation (if applicable)
- ☐ **Form #10** Safety Violation (if applicable)

Step 4: Direct Medical Treatment - Designate an Authorized Occupational Medical Provider

- ☐ **Form #11** Post Accident Drug Test Consent (if applicable)
- ☐ **Form #12** Refusal of Medical Treatment (if applicable)

Step 5: Submit Completed Forms to MMMA-Claims Management of Missouri

- ☐ Email: adjusters@mmm-a.com (preferred)
- ☐ Fax: 636-537-1362

IN CASE OF WORKPLACE INJURY

ACCION a seguir en caso de un accidente en el trabajo

24/7 NurseNow Claim Reporting

1-855-704-3555

Including After Hours, Holidays and Weekends

MMMA - Claims Management of Missouri, LLC

Regular Business Hours (M-F) 8:00 am - 4:30 pm

Phone: **1-636-537-4613**

Toll Free: **1-888-805-8765**

1 **Injured worker notifies supervisor.**
Empleado lesionado notifica a su supervisor.

2 **Supervisor with injured worker immediately calls injury hotline including after hours, weekends or holidays.**
Supervisor/Empleado lesionado llama inmediatamente ala líneade enfermeros/as.

3 **The 24/7 NurseNow Hotline gathers information over the phone and helps injured worker assess appropriate medical treatment.**
Profesional Médico obtiene información por teléfono y asiste al empleado lesionado en localizer el tratamiento médico adecuado.

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Claims | Claims Management of Missouri, LLC
Mgmt of MO

NOTICE TO EMPLOYER/SUPERVISOR

Please post copies of this poster in multiple locations within your worksite. If the after hours, weekends or holidays injury is non-life threatening, please call Missouri Merchants & Manufacturing Association Self-Insured Worker's Compensation Fund/Claims Management NurseNow prior to seeking treatment. Minor injuries should be reported prior to leaving the worksite when possible.

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24/7 NurseNow Hotline Q & A

Missouri Merchants & Manufacturers Association SIWCF–Claims Management of Missouri, LLC has implemented an injury management program called NurseNow Triage Hotline. When you encounter a workplace injury, the Supervisor and injured employee will call the injury hotline as soon as possible after the incident occurs. After the nurse at NurseNow records the injury and incident information, the attending nurse will provide first aid advice and if needed, recommend additional treatment. **If life-threatening or limb-threatening injury, call 911!!**

Important NurseNow Facts :

- If an injury is not a true medical emergency, the Supervisor and the Employee will telephone the Nurse Triage Hotline at 1-855-704-3555 before seeking medical treatment. They will speak with a Professional Nurse who will assist the employee with his or her medical needs which expedites the claims processing.
- The nurse will talk to the supervisor first and then the employee to determine what kind of treatment, if any, is necessary for the employee based upon their conversation with the employee and the supervisor.
- The Nurse Triage Hotline will complete First Report of Injury report and forward to MMMA.
- The Supervisor and/or Employee only need to report the injury once to the NurseNow Triage Hotline. However, you can call back any time with changes or updates to the report if needed.

The advantage of a medical professional assisting in directing the employee's medical treatment should result in cost savings and fewer claims if first aid can be applied. Furthermore, employees will receive instant telephonic first aid advice from an experienced Local Missouri Nurse, and be recommended for further treatment if needed. Your cooperation and participation is appreciated.

Q. Should every workplace injury be reported to the Nurse Triage Hotline?

A. Yes, report all injuries and referrals to the NurseNow Hotline. CALL THE NURSE TRIAGE HOTLINE BEFORE THE EMPLOYEE LEAVES THE JOB SITE. This will provide injury information immediately to Management personnel on every injury. This is a 24/7 service, including all holidays.

Q. Does the Nurse Triage Hotline diagnose an injury over the telephone?

A. We do not diagnose injuries. We perform a triage process that guides the employee to the appropriate level of care for treatment based on the information obtained during the call.

Q. The employee was referred for treatment by the nurse. The employee and the supervisor do not think this injury needs to be treated. Should treatment be sought anyway?

A. Yes. It is always best to follow the advice of the RN and get treatment sooner rather than later. Minor injuries are often referred to seek treatment within 48-72 hours. If the employee refuses to seek treatment, that will be documented in the incident report. At minimum, self-care treatment will be provided.

Q. The employee does not want to call the Nurse Triage Hotline. Should the supervisor call?

A. Yes. However, the employee must be present as the nurse can only triage the injured worker.

Q. Will the employee be given some type of reference or call confirmation number?

A. Yes, we provide a call confirmation number that associates the employee's injury to a specific report.

Q. What happens if the employee is on hold for an extended period of time waiting for a nurse?

A. The protocol is to answer every call. Your call will be answered by a Professional Nurse. In the event of high volume, there is an option to leave a message for call back at which time your call will be returned in less than 15 minutes.

Q. After the Employee has been treated by the authorized medical provider, do they need to call the Nurse Triage Hotline back and update them with the treatment outcome and/or progress?

A. No. The Nurse Triage Hotline does not need to know. Any updates of your condition after treatment should be provided to your employer.

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Supervisor Incident Report

Supervisor Name & Department	Date of Incident	Date Incident Reported
Injured Employee Name	Incident Reported to	
Time of Incident ☐ A.M. ☐ P.M.	Time Incident Reported ☐ A.M. ☐ P.M.	
Location of Incident	Job Injured Employee Performing	
Type of Injury ☐ Near Miss ☐ Injury ☐ Property Damage	Was Employee on Duty at Time of Injury? ☐ Yes ☐ No	
Location of Incident	Did Injury Result in Lost Time? ☐ Yes ☐ No	
Was Injury Caused by a Non-Company Person? ☐ Yes ☐ No	By Faulty Equipment? ☐ Yes ☐ No	
Description of Incident *(Explain how incident occurred) — Use Separate Sheet If Needed*		
Do You Know of Any Other Witnesses? ☐ Yes ☐ No *If Yes, List Name(s) and Have Them Complete a Witness Incident/Injury Report*		
Referred For Medical Treatment? If Yes, Check All That Apply: ☐ Yes ☐ No ☐ Occupational Medicine Clinic ☐ Hospital Emergency Room ☐ Transported by Ambulance		
Do You Think The Incident Occurred Due to an Unsafe Condition?		
Do You Know of Any Other Similar Incidents Occurring in the Past? ☐ Yes ☐ No OR Due to Unsafe Act? ☐ Yes ☐ No		
Do You Think This Incident Could Have Been Prevented? ☐ Yes ☐ No		
How Do You Think This Incident Could Have Been Prevented?		
Print Name of Person Completing This Report		
Signature of Person Completing This Report	Current Date	
Fax or e-mail completed form to:	**MMMA-Claims Management of Missouri, LLC** **15450 South Outer 40 Road, Ste. 200** **Chesterfield, MO 63017-4817** **Fax: 636-537-1362** **E-mail: adjusters@mmm-a.com**	

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Witness Statement

Name	Date of Incident	Date of Report
Address	Witness Job Description	
City/State/Zip	Employer *(If Not an Employee)*	
Phone Number ☐ Home ☐ Cell	Person Incident Reported to	
Time of Incident ☐ A.M. ☐ P.M.	Location of Incident	
Description of Incident *(Explain how incident occurred) — Use Separate Sheet If Needed*		
Do You Know of Any Other Witnesses? ☐ Yes ☐ No	Do You Know of Any Other Similar Injuries? ☐ Yes ☐ No	
If Yes, List Names	How Do You Think The Incident Occurred *(Unsafe Condition or Act?)*	
How Do You Think This Incident Could Have Been Prevented?		
Print Name of Person Completing This Report		
Signature of Person Completing This Report		Current Date
Fax or e-mail completed form to:	**MMMA-Claims Management of Missouri, LLC** **15450 South Outer 40 Road, Ste. 200** **Chesterfield, MO 63017-4817** **Fax: 636-537-1362** **E-mail: adjusters@mmm-a.com**	

FORM #2

MMMA | SELF-INSURED WORKERS' COMPENSATION FUND

Employee Incident Report

Name	Date of Incident	Date of Report
Address	Date of Birth	
City/State/Zip	Social Security #	
Phone Number ☐ Home ☐ Cell	Job Performed	
Time of Incident ☐ A.M. ☐ P.M.	Employer (if not an employee)	
Location of Incident	Person Incident Reported to	
Description of Incident *(Explain how incident occurred) — Use Separate Sheet If Needed*		
Do You Know of Any Other Witnesses? ☐ Yes ☐ No	Do You Know of Any Other Similar Injuries? ☐ Yes ☐ No	
If Yes, List Names	How Do You Think The Incident Occurred *(Unsafe Condition or Act?)*	
How Do You Think This Incident Could Have Been Prevented?		
Print Name of Person Completing This Report		
Signature of Person Completing This Report		Current Date
Fax or e-mail completed form to:	**MMMA-Claims Management of Missouri, LLC** **15450 South Outer 40 Road, Ste. 200** **Chesterfield, MO 63017-4817** **Fax: 636-537-1362** **E-mail: adjusters@mmm-a.com**	

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Employee Pain Chart

Injured Employee Name: _____

Employer Name: _____

Date of Incident: _____

Please circle all that apply:

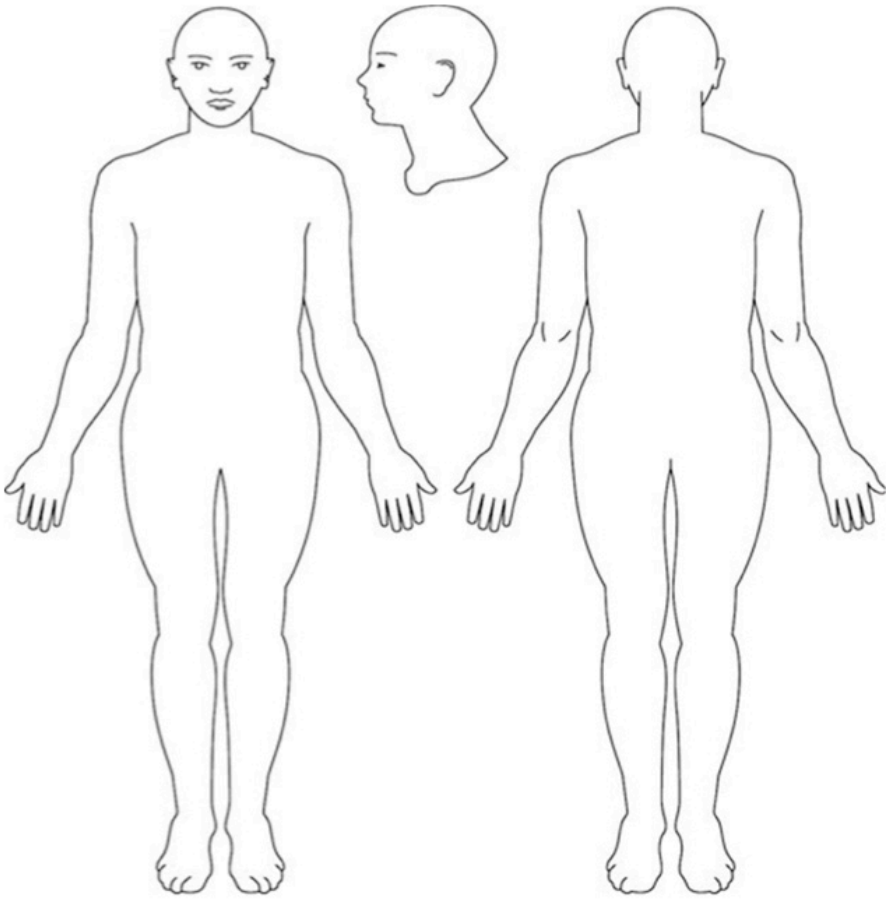
My pain is worse:

A) in the morning B) during the day C) at night D) constant E) with activity F) during rest

On a scale of 0 (no pain) to 10 (unbearable pain requiring hospitalization) - please rate your pain:

At its BEST: _____ At its WORST: _____

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition:



KEY:

^^^ = Radiating Pain

xxx = Spasms

zzz = Tenderness

/ / / = Numbness / Tingling

000 = Aches / Pain

Injured Employee Signature: _____ Date: _____

FORM #4

MMMA | SELF-INSURED WORKERS' COMPENSATION FUND

Employee HIPAA Medical Release

Patient Information:

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip _____

Social Security #: _____ Phone: _____

Claim #: _____

Date of Incident _____ Employer: _____

I hereby authorize: "ANY & ALL Health Care Provider(s)" to release the following information to:

MMMA-Claims Management of Missouri, LLC
15450 South Outer 40 Road, Ste. 200
Chesterfield, MO 63017
Fax: 636-537-1362

Information to be released: ANY and ALL records

- ☐ Complete Health Record
- ☐ Consultation Reports
- ☐ X-Ray Films/Images
- ☐ History & Complete Physical Exam
- ☐ X-Ray Reports
- ☐ Itemized Bill
- ☐ Laboratory Test Results
- ☐ Complete Billing Record
- ☐ Photographs, Videotapes
- ☐ Discharge Summary
- ☐ Diagnosis & Treatment Codes
- ☐ Progress Notes
- ☐ Other: _____

Purpose of Request:

This authorization is being completed at the request of the patient pursuant to litigation. Please note that this authorization includes medical records, reports and other medical documents in your possession, which relate to any prior or subsequent complaints, injuries, illnesses or other conditions involving the same parts of the body and the same or similar conditions described below. This Authorization includes but is not limited to records of all examinations, treatments and tests, including inpatient, outpatient and emergency room, whether for diagnostic or prognostic purposes, consultation reports, correspondence, x-rays, photographs, videotapes, MRI's and CT scans and post-mortem records, if applicable, PROVIDED that the examinations, treatments and/or tests involve or relate to complaints, injuries or illnesses or conditions pertaining to the following the alleged above injury.

The health care provider is neither required nor prohibited by law from engaging in private conversations regarding the patient's above referenced care. The decision to enter into any such conversation is that of the health care provider. However, disclosure that exceeds the scope of this Authorization may subject the health care provider to civil liability.

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Employee HIPAA Medical Release

Drug and/or Alcohol Abuse and/or Psychiatric, and/or HIV/AIDS Records Release:

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

☐ YES ☐ NO

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release.

☐ YES ☐ NO

Expiration of Authorization:

This Authorization shall remain in effect until the underlying claim is finally resolved. Therefore, you may receive a supplemental request for documents. Provided you have this Authorization allowing you to provide records to the party making the supplemental request, a written request for supplemental documents is sufficient, and no additional Authorization is required. It is expressly agreed that a photocopy of this Authorization shall be as valid as an original.

Who & Where to Send / Release Information:

MMMA-Claims Management of Missouri, LLC
15450 South Outer 40 Road, Ste. 200
Chesterfield, MO 63017
Fax: 636-537-1362

Right to Revoke Authorization:

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. I understand that if I want to cancel/revoke this Authorization, I must mail or fax a letter to Claims Management of Missouri stating that I want to cancel this Authorization.

Re-Disclosure:

I understand that information disclosed by this Authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure:

I understand that I do not have to sign this Authorization and my treatment or payment for services will not be denied if I do not sign this form. I understand that I am entitled to a copy of the Signed Authorization and that I can inspect or copy the protected health information to be used or disclosed.

Patient Signature: _____ Date: _____

Authorized Signature (If Other Than Patient): _____

Employer Name: _____ Date: _____

Claims | Claims Management of Missouri, LLC | Mgmt of MO

CompPBM™ PHARMACY MANAGEMENT

First Fill Temporary Pharmacy Card

Employer:

1. Please fill out the card below with Injured workers' information.
2. Distribute this card to the injured worker.

Injured Employee:

1. If you need a prescription filled related to a work-related injury or illness, go to a CompPBM network pharmacy.
2. Give this page to the pharmacist.
3. The pharmacist will fill your prescription at no cost.

Pharmacist:

1. The member ID is made up of the above SSN+ Date of Injury --Member ID Format 123MMDDYY--
2. Call the CompPBM Help Desk at 844-987-0011 at anytime if you have questions.

Questions? ¿Necesitas ayuda en español? Llame al

844-987-0011

Prescription Card

Claims | Claims Management of Missouri, LLC | Mgmt of MO

Claims Management of Missouri

Carrier/TPA Employer

Injured Worker Name

Last 3 digits of SSN Date of Injury (MMDDYY)

Notice to Cardholder: This card should be presented to your pharmacy to receive medication for your work-related injury. It is only valid for 10 days after the first processed prescription. Information regarding the program or to find nearby pharmacies call 844-744-4726 or scan the QR code

Attention Pharmacists: Please be aware of first fill limitations including maximums of 10 days supply and $250 for each processed prescriptions. If the medication falls outside of these limits, please call the Help Desk for prior authorization.

BIN: 021031
GROUP: 71954002
PCN: CPBM
PERSON CODE: 01

Help Desk: 844-987-0011

Contact and Pharmacy Lookup

Finding a Network Pharmacy:

- Scan the QR code above
- Visit comppbm.com/pharmacylocator
- Call us at 844-987-0011

FORM #6

MMMA | SELF-INSURED WORKERS' COMPENSATION FUND

Wage Statement

Employee Name: _____

Claim #: _____

Date of Incident: _____

Employer Name: _____

Please Note: The Missouri Division of Workers' Compensation requires a copy of your system payroll report (or) check copies

Reported "Gross" Wages - 13 Weeks "PRIOR" to Date of Injury or 14 Weeks if paid bi-weekly.

Other/Codes: Vacation (V), Overtime Pay (OT), Bonus (B), Gratuities (G), Lodging (L)

Insurance: Health (H), Life (L), Dental (D), Vision (V), Other (O)

	GROSS WAGES		PAY PERIOD		*OTHER/Code
WEEK 13:	$ _____	=	_____ to	_____	$ _____ ( )
WEEK 12:	$ _____	=	_____ to	_____	$ _____ ( )
WEEK 11:	$ _____	=	_____ to	_____	$ _____ ( )
WEEK 10:	$ _____	=	_____ to	_____	$ _____ ( )
WEEK 09:	$ _____	=	_____ to	_____	$ _____ ( )
WEEK 08:	$ _____	=	_____ to	_____	$ _____ ( )
WEEK 07:	$ _____	=	_____ to	_____	$ _____ ( )
WEEK 06:	$ _____	=	_____ to	_____	$ _____ ( )
WEEK 05:	$ _____	=	_____ to	_____	$ _____ ( )
WEEK 04:	$ _____	=	_____ to	_____	$ _____ ( )
WEEK 03:	$ _____	=	_____ to	_____	$ _____ ( )
WEEK 02:	$ _____	=	_____ to	_____	$ _____ ( )
WEEK 01:	$ _____	=	_____ to	_____	$ _____ ( )

TOTAL WAGES: $_____ / 13 WEEKS = $ _____ = _____ GROSS AWW

Submit Completed Form to:

MMMA-Claims Management of Missouri, LLC
15450 South Outer 40 Road, Ste. 200
Chesterfield, MO 63017

Fax: 636-537-1362
Email: adjusters@mmm-a.com

FORM #7

MMMA | SELF-INSURED WORKERS' COMPENSATION FUND

Light Duty Offer

Today's Date: _____

Employee Name: _____

Employer Name: _____

Date of Incident: _____

Claim #: _____

Authorized Treating Physician: _____

Notice to Injured Employee:

_____ As your employer, we CAN accommodate light duty work under workers' compensation.

_____ As your employer, we CANNOT accommodate light duty work under workers' compensation.

*** **If light duty can be accommodated, you will be required to report to work on the first available work day following your light duty release.*****

Employee Signature: _____ Date: _____

I have advised our employee (in person / by phone / by mail) that light duty is available and he/she is expected to return to work on the next available return to work date.

Employer Signature: _____ Date: _____

Submit Completed Form to:

MMMA-Claims Management of Missouri, LLC
15450 South Outer 40 Road, Ste. 200
Chesterfield, MO 63017
Fax: 636-537-1362
Email: adjusters@mmm-a.com

MMMA | SELF-INSURED WORKERS' COMPENSATION FUND

Drug/Alcohol Violation

Missouri - Division of Workers' Compensation - Section 287.120.6, RSMo

Today's Date: _____

Employee Name: _____

Employer Name: _____

Date of Incident: _____

Claim #: _____

IF the employee fails to obey any rule or policy adopted by the employer on a drug-free workplace or on the use of alcohol or non-prescribed controlled drugs in the workplace, and the employee sustains an injury while using alcohol or non-prescribed controlled drugs, the compensation and death benefits shall be reduced 50%.

IF the employee's use of alcohol or non-prescribed controlled drugs in violation of the employer's rule or policy is the proximate cause of the employee's injury, the benefits or compensation payable for death or disability are forfeited.

** **Under the law, there is a rebuttable presumption that the alcohol was the proximate cause of the injury if the voluntary use of the alcohol to the percentage of blood alcohol in the employee's system meets the legal intoxication standard under Missouri law.**

** **An Employer can request an employee to take a test for alcohol or a non-prescribed controlled substance if the employer suspects usage by the employee or IF the employer's policy clearly authorizes the post injury testing. IF the employer does request a test of the employee when an injury occurs and the employee refuses to take the test, the employee forfeits ALL workers' compensation benefits.**

Violation: _____

_____

_____

_____ Yes, I am aware of my Employer's Drug/Alcohol Policy regarding the above violation.
(Employee Initials)

Employee Signature: _____ Employee Printed Name: _____

Supervisor Signature: _____ Supervisor Printed Name: _____

_____ Copy of our Company Policy is Attached (signed handbook, safety sheets, etc.)

_____ Copy of our Company Policy Will Be Sent Via Fax or E-Mail

_____ Witness Statement(S) Are Attached

_____ Witness Statement(S) Will Be Sent Via Fax or E-Mail

FORM #9

MMMA | SELF-INSURED WORKERS' COMPENSATION FUND

Safety Violation

Missouri - Division of Workers' Compensation - Section 287.120.5, RSMo

Today's Date: _____

Employee Name: _____

Employer Name: _____

Date of Incident: _____

Claim #: _____

IF an employee has an injury caused by the employee's failure to use safety devices provided by the Employer or failure to obey a reasonable safety rule of the employer, the compensation and death benefits are reduced at least 25% but not more than 50%.

1. **The Employee had actual knowledge of the Employer's safety rule.**
2. **The Employer had made a reasonable effort to make sure the employee used the safety device or obey the safety rule.**

Violation: _____

_____

_____

_____ Yes, I am aware of my Employer's Drug/Alcohol Policy regarding the above violation.
(Employee Initials)

Employee Signature: _____ Employee Printed Name: _____

Supervisor Signature: _____ Supervisor Printed Name: _____

_____ Copy of our Company Policy is Attached (signed handbook, safety sheets, etc.)

_____ Copy of our Company Policy Will Be Sent Via Fax or E-Mail

_____ Witness Statement(S) Are Attached

_____ Witness Statement(S) Will Be Sent Via Fax or E-Mail

MMMA | SELF-INSURED WORKERS' COMPENSATION FUND

Post-Accident Drug/Alcohol Test Consent

Workers' Compensation Post Accident - Drug / Alcohol Testing

Date: _____

Patient Name: _____

Company: _____

Date of Loss: _____

Body Part: _____

(Photo ID Required)

Drug Screen: YES _____ (initials)
(Non-DOT)

Alcohol Screen: YES _____ (initials)
(breath OR urine acceptable)

****** Fax Results immediately to:** _____ ****

Attn: _____

Authorized By: _____
(Company Signature)

Printed Name: _____

On behalf of Company: _____

Phone Number: _____

MMMA | SELF-INSURED WORKERS' COMPENSATION FUND

Refusal of Medical Treatment
FOR A WORK-RELATED INJURY

I, *(injured employee)* _____, acknowledge that medical treatment has been offered by *(employer)* _____, my employer, for the injury I sustained at my place of work on *(date)* _____, and that I have refused the offered medical treatment.

I understand that my employer has the right to choose a medical provider for any work related injury. I also understand that payment for any medical treatment I receive related to the work injury that is not authorized by my employer will be at my own expense.

Employee Signature _____ Date: _____