EMPLOYEE AGREEMENT
EMPLOYEE SAFE WORKING PRACTICES/MANAGED CARE

As a condition of employment, I ____ do hereby agree to
(Please print full name)
comply with the following Employee Safe Working Practices and Managed Care Program.

1. I agree to follow established departmental safety procedures.

2. I agree to report any work-related accident or injury to my supervisor as soon as it occurs, but no later than the end of my duty shift.

3. If I need treatment for a work-related injury, I understand that my employer has enrolled in a Managed Care Program for Workers' Compensation with ***FHM Insurance Company WECARE program and AmeriSys/Coventry Network*** and that the following procedures must be followed for all work-related injuries and illnesses. It is important to note that Florida Statute 440.134(17) states "**...Treatment received outside the Workers' Compensation managed care arrangement is not compensable unless authorized by the carrier prior to the treatment date.**"

- ✓ Report promptly any work-related injury to supervisor.
- ✓ Hand carry the Introductory Letter to Physician to the Medical Care Coordinator on the initial visit.
- ✓ Follow the Medical Care Coordinator's instructions for any additional specialist treatment, if needed.
- ✓ **Ensure all medical treatment is handled only through the Medical Care Coordinator.**
- ✓ Direct all questions about level of care to the Medical Care Coordinator, who is the focal point for medical treatment.
- ✓ Follow established Grievance Procedures to resolve any dissatisfaction with medical treatment.

I understand that failure on my part to follow the above procedures could result in disciplinary action not to exclude termination and loss of Workers' Compensation benefits.

I also understand that according to Section 440.09(5) of the Florida Workers' Compensation Law, my compensation benefits could be reduced for any injury that occurs because of failure to follow established safety procedures.

____ ____________________
Employee Signature Date

____
Witness Signature

Original to Personnel File / Copy to Employee

Introductory Letter to Physician

AmeriSys/Coventry Network

Date: ____
Employer Name: ____
Employer Telephone Number: ____

Dear Dr. ______________________:

____ is scheduled for an initial visit as an employee of ____which is a participant in the **FHM Insurance Company/AmeriSys/Coventry Network**. This letter does not confirm that the injury or condition is covered by Workers' Compensation insurance. That determination will be made as soon as an investigation is completed by our claims administrator, USIS.

DRUG TESTING IS REQUIRED:

- ☐ Urinalysis
- ☐ Breathalyzer (blood test if necessary)

We are working closely with AmeriSys/Coventry Network and the involved medical providers to ensure that our employees receive access to timely and medically necessary treatment for their industrial injuries. In the best interest of our employees, we will have modified work available, which would allow the employee to return to work at the earliest possible date. Please keep this in mind as you treat this employee.

PLEASE CONTACT UTILIZATION MANAGEMENT
AT 888-346-3461 Ext. 131
WHEN ONE OF THE FOLLOWING OCCURS:

1. New Injury with Disability > 7 Days & No Release to Return to Work
2. Hospitalization
3. Anticipated Surgery
4. Physical Therapy or Chiropractic Treatment Recommended
5. Referral to Provider
6. Assistance Required to Return Injured Employee to Work
7. Repeat Major Diagnostic Studies

All claims for treatment must be submitted to the address below on an HCFA 1500, UB 92 or the appropriate form required by the State. Please submit all medical reports within the time frame required by the applicable State law.

FHM Insurance Company
P.O. Box 616648, Orlando, FL 32861-6648
407-351-1212/888-346-3461 Ext 350

Should you have any questions regarding your participation in the Coventry Network, please call 800-342-5888 or 800-937-6824.

Sincerely,

______________________________	______________________________
Print Name	**Signature**

FHM Insurance Company

WECARxE

WORKERS' COMPENSATION

GRIEVANCE PROCEDURE / DISPUTE RESOLUTION

IF YOU ARE INJURED ON THE JOB

Your employer and Workers' Compensation carrier are concerned that you receive appropriate medical treatment.

Your employer has a list of health care providers and can assist you in selecting a provider from within the Coventry Network. If you need to be referred to another provider or need emergency care, you may choose from the list of providers participating in the Network.

If you are dissatisfied or have questions concerning the medical care and treatment provided by a **WECARxE** provider, you may, within one year from the date of treatment or care in question, file a complaint by contacting the Grievance Coordinator or your Nurse Case-Manager at 888-346-3461.

The Grievance Coordinator and/or Nurse Case-Manager will coordinate a resolution to the complaint/grievance. The Dispute Resolution process will be completed within thirty (30) days of receipt of the written notice. This process is in compliance with Georgia MCO rule.

If you have any questions concerning the Coventry Network, please call 888-346-3461 ext.131.

FHM Insurance Company
Internal Dispute Resolution/Grievance Form

Employee Name:	Provider Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Phone #	Phone #
SS#:	SS#:

Please describe your grievance in detail below. Include dates, names and the specific resolutions which you feel would remedy the situation. Then mail this form to the address noted below or call 800-752-0886, extn 102, Cheryl Gulasa RN, CPUR, CCM

Issue: Service ________ Medical Care _________ Other: _________

Date of injury: ___________ Date of dissatisfaction: ___________

Please describe:

____

____

____

____

____

____

____

____ _________________________

Signature Date

____

Cheryl Gulasa, Dispute Resolution Coordinator
140 Alexandria Blvd., Suite H
Oviedo, FL 32765
(800) 752-0886

FHM INSURANCE COMPANY

A POLICY TO DO MORE®

Workers' Comp Since 1954

888-346-3461 | www.fhmic.com

WORKERS' COMPENSATION WECARxE NETWORK PROVIDER NOMINATION FORM

All information in the box below must be completed prior to forwarding to Focus.
The form will be returned if incomplete.

Employer Name: ____________________

Address: ____________________

City, State, Zip: ____________________

Telephone #: ____________________

Requestor Name: ____________________

Requestor Telephone #: ____________________

Provider Name: ____________________

Group Name: ____________________

Provider Specialty: ____________________

Address: ____________________

City, State, Zip: ____________________

Telephone #: ____________________

Client's $ volume with provider: ____________________

Period represented: From: To:

Source of Data (1099): ____________________

Other: ____________________

Tax ID # (if available): ____________________

Contact Person (if available): ____________________

Hospital Affiliation (if known): ____________________

Reason for Nomination: ____________________

Comments: ____________________

Signature: ____________________ Date: ____________________

Please forward to:

AmeriSys
Attn: Leslie Whittemore
PO Box 616648
Orlando, FL 32861-6648
888-346-3461 x120 / Fax #: 407-949-3170

Internal Use Only:
Date Received: ____________________ Managed Care Representative: ____________________
Recruitment Letter Sent:
Date of Last Contact:
Current Status: ____________________