

**EMPLOYEE AGREEMENT
EMPLOYEE SAFE WORKING PRACTICE/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. 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 approved network physician on the initial visit.
 - ✓ Follow the approved network physician's instructions for any additional specialist treatment, if needed.
 - ✓ **Ensure all medical treatment is handled only through the approved network physician.**
 - ✓ Direct all questions about level of care to the approved network physician, who is the focal point for medical treatment.
 - ✓ Follow your state's established procedures to resolve 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 Workers' Compensation Law, my compensation benefits could be reduced for any injury that occurs because of failure to follow established safety procedures.

Employee

Date

Witness Signature

Date

Original to Personnel File / Copy to Employee

FHM Insurance Company
WECARE®
WORKERS' COMPENSATION

GRIEVANCE PROCEDURE

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 **WECARE** provider, you may, within one year from the date of treatment or care in question, file a complaint by contacting the Grievance Coordinator at 888-346-3461 x417.

The Grievance Coordinator and/or Nurse Case-Manager will coordinate a resolution to the complaint and contact a Physician Advisor if necessary. The Physician Advisor may require medical examinations and/or other information from you and the Network provider depending on the nature of the dispute. If the Physician Advisor is unable to resolve the dispute to your satisfaction within ten (10) days, the matter will automatically be referred to the Medical Director.

The Medical Director will issue a decision within thirty (30) days unless further information is required, in which case an additional thirty (30) days will be allowed. If an agreement is not reached and you are not satisfied with the decision of the Medical Director, you may file a request for reconsideration with the Division of Workers' Compensation.

If you have any questions concerning the Coventry Network, call 888-346-3461, ext. 120 or write to:

Coventry Health Care Workers' Compensation, Inc.
3200 Highland Avenue
Downers Grove, IL 60515

**Florida Workers' Compensation Managed Care Arrangement
FORMAL GRIEVANCE FORM**

An Injured Worker or Health Care Provider shall use this form to request a formal review about dissatisfaction with medical care issues provided by or on behalf of a Workers' Compensation Managed Care Arrangement.

This Grievance is Filed by: Provider Injured Worker or a Designated Representative: Family Member Attorney Other
Date of Injury _____

INJURED WORKER'S/PROVIDER'S NAME: _____
Social Security Number _____
Address: _____
Home Telephone: _____ Work/Alternate Phone: _____
Contact if other than injured worker or provider _____ Telephone # _____

PRIMARY CARE/TREATING PHYSICIAN: _____
Address: _____
Office Telephone: _____

If the space provided below is inadequate for you to fully explain your concern or the action you desire, continue your statement on a sheet of plain paper. Please be sure your name and social security number appear on each page of any attachment.

Why is this grievance being filed? (Nature of the problem): _____

Has a grievance been previously filed? YES NO IF YES, Date sent? _____

What Action Would You Like to See Taken? _____

Have you received any information regarding your rights and responsibilities under WC Managed Care? Yes No

INTENT: The grievance procedure is intended to be self-executing and easy to use. An injured worker may call the grievance coordinator directly without completing this form. The grievance coordinator may complete the form for the injured worker. A review regarding the requested medical care will begin immediately, and a decision made within 44 days of receipt unless additional information is required from outside the service area. The review period may be extended by mutual agreement between the injured worker and the grievance coordinator, with notice provided to all other participating parties.

The injured worker's participation in the grievance process is important to the resolution of medical issues. Individuals reviewing the grievances may need to speak directly with and receive input from the injured worker. If the injured worker is unable to participate actively in the grievance process, a patient advocate may participate on behalf of the injured worker.

If the injured worker, employer, or carrier is dissatisfied with the final decision of the grievance committee, the dissatisfied party has the right to file a Petition for Benefits with the Florida Division of Workers' Compensation.

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

Form Completed by: _____
Injured Worker/Provider/Other

Date Form Completed/Signed

Signature of Grievance Coordinator

Date Grievance Coordinator Signed

MAIL TO: Grievance Coordinator AmeriSys PO Box 616648, Orlando, FL 32861-6648
