FREEMAN ADMINISTRATIVE SOLUTIONS, INC. (FAS)
P.O. BOX 2309
ADDISON, TX 75001-2309
PHONE: 972-930-9493 OR TOLL FREE 866-930-9493
FAX: 972-930-9479 Or Email: CLAIMS@FASTPA.COM

ACCIDENT REPORTING PROCEDURES

When an injury (or alleged injury) occurs:

- See that the injured employee receives **prompt medical attention,** and complete the initial **"Medical Treatment Authorization"** form, including the "Drug/Alcohol Screen" section. The form is sent with the injured employee to the medical facility.
- Send the employee to an occupational accident medical facility.

Immediately upon notification of an incident:

- Have the injured employee complete and sign the **Employee Statement of Injury** form.
- Have the employee sign the **Medical Record Release Authorization.**
- Complete the **Supervisor's Incident Report**.

Review the forms and make sure they are complete, signed and have your Company Name listed. Make copies of the attached forms for your records and future use.

Immediately upon completion of the forms, **fax** OR **email** them to:

FAX: (972) 930-9479 or E-mail address CLAIMS@FASTPA.COM

Accidents resulting in death or severe injury should be reported *immediately by telephone*.
Call 972-930-9493 or Toll free 1-866-930-9493.

After FAS has received the completed notice and forms, you will be sent an acknowledgement letter. All medical bills should be submitted to FAS for approval and audit prior to payment.

If you should have any questions concerning a claim, do not hesitate to call us at 1-866-930-9493 between 8:00 A.M. and 5:00 P.M. Monday through Friday.

FREEMAN ADMINISTRATIVE SOLUTIONS, INC. (FAS)

Claims Kit

***Includes*:**
Accident Reporting Procedures

FORMS:

EMPLOYEE STATEMENT OF INJURY
SUPERVISORS INCIDENT REPORT
WITNESS STATEMENT
MEDICAL TREATMENT AUTHORIZATION
PHYSICIAN'S REPORT OF EMPLOYEE INJURY
MEDICAL RECORDS RELEASE AUTHORIZATION
DECLINE MEDICAL TREATMENT FORM

REVIEW FOR COMPLETENESS

FAX OR EMAIL REPORT NOTICES TO:

FAS

FAX: (972) 930-9479
Or
CLAIMS@FASTPA.COM

Should you have any questions regarding any of these forms, please contact our office at (866) 930-9493 between 8:00 a.m. and 5:00 p.m., Monday through Friday.

EMPLOYEE STATEMENT OF INJURY

THIS REPORT IS TO BE COMPLETED IN ITS ENTIRETY BY THE EMPLOYEE
Fax or Email this completed form to *FAS (972) 930-9479 or CLAIMS@FASTPA.COM*

EMPLOYER INFORMATION: ____

ADDRESS: ______________________ City: ________________ State TX Zip: __________

PHONE: ( ) __________ FAX: ______________________ Policy# ______________

EMPLOYEE INFORMATION:

NAME ______________________ D.O.B. ___/___/___ **SOCIAL SECURITY NO.** ____________

HOME ADDRESS ____

CITY ______________________ STATE ______ ZIP __________ PHONE ( ) __________

OF DEPENDENTS (IF ANY) __________ MARITAL STATUS ____________ GENDER ☐ MALE ☐ FEMALE

PREFERRED LANGUAGE IF OTHER THAN ENGLISH ______________________

INJURY INFORMATION

DATE OF INCIDENT ___/___/___ **TIME OF INCIDENT** __________ ☐**A.M.** ☐ **P.M.** **DAY OF WEEK** __________ **TIME WORKSHIFT STARTED** ________ ☐ **A.M.** ☐ **P.M.**

DATE I REPORTED NJURY TO MANAGER ___/___/___ TIME REPORTED ______________ ☐ **A.M.** ☐**P.M.**

ADDRESS WHERE INJURY OCCURED ______________________________ CITY ____________

STATE ________ ZIP __________ PHONE ( ) ______________ FAX ( ) ____________

EXACT AREA WHERE INJURED ____

DESCRIBE EQUIPMENT INVOLVED (IF ANY) ______________________________________

____

DESCRIBE WHAT YOU WERE DOING AT TIME OF INCIDENT ____________________________

____

DESCRIBE FULLY HOW THE INCIDENT OCCURRED ___________________________________

____

____

WAS A SAFETY DEVICE APPLICABLE? ☐ YES ☐ NO WAS IT USED? ☐ YES ☐ NO IF YES INDICATE THE DEVICE APPLICABLE ______________________________________

DESCRIBE NATURE OF INJURY ____

____

BODY PART(S) INVOLVED ____

HAVE YOU HAD A SAME OR SIMILAR INJURY BEFORE? ☐ YES ☐ NO IF YES, GIVE DETAILS ____________

____

I, ______________________ (Employee), the undersigned herewith CERTIFY that the foregoing statements and answers on this form are complete and true, and that no information has been omitted, and that I made such statements and answers of my own free will. I understand that my Employer does not carry Workers' Compensation insurance, and furthermore, that any payments to me or anyone else for expenses in connection with this incident and resulting in injury is not an admission of liability on the part of my Employer.

I authorize direct payment to medical providers and others rendering services in connection with this claim.

Employee Signature ______________________ Witness ______________________ Date __________

Translated by (if applicable) ______________________________________ Date __________

Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

SUPERVISORS INCIDENT REPORT

THIS REPORT IS TO BE COMPLETED IN ITS ENTIRETY BY THE EMPLOYER
Fax or Email this completed form to *FAS (972) 930-9479 or CLAIMS@FASTPA.COM*

EMPLOYER NAME: ______________________________ Policy# ______________

LOCATION: (If different from above) ______________________ LOCATION NO.: ______________

DEPARTMENT: ______________ JOB TITLE: ______________ DATE OF HIRE: ____/____/____

SCHEDULED DAYS/WEEK: __________ SCHEDULED HOURS/DAY: __________ HOURLY RATE: $__________

TIME LOST FROM WORK? YES ☐ NO ☐ FIRST DAY OF LOST TIME: ____/____/____

DATE RETURNED TO ☐ FULL ☐ MODIFIED / DUTY: ____/____/____

EMPLOYEE INFORMATION:

NAME: ______________________________ **SOCIAL SECURITY NO**: ______________

HOME ADDRESS: ______________________________

CITY: ______________ STATE: ______ ZIP: ______________ PHONE: (______) ______________

GENDER ☐ MALE ☐ FEMALE PREFERRED LANGUAGE IF OTHER THAN ENGLISH: ______________

BASIC INJURY INFORMATION

DATE OF INCIDENT: ____/____/____ **DAY OF WEEK:** ______________ **TIME OF INCIDENT:** ______________ ☐A.M. ☐ P.M.

DATE REPORTED INCIDENT: ____/____/____ **DAY OF WEEK:** ______ **TIME REPORTED INCIDENT:** ______ ☐A.M. ☐ P.M.

NAME OF SUPERVISOR WHEN INJURY OCCURRED: ______________________ CONTACT PHONE #: (______) ______________

DESCRIBE NATURE OF THE EMPLOYEE'S INJURY: ______________________________
BODY PART(S) INVOLVED: ______________________________

DESCRIBE EQUIPMENT INVOLVED (IF ANY): ______________________________

WITNESS INFORMATION (IF NONE PLEASE INDICATE NONE)

NAME OF WITNESS: ______________________ HOME PHONE: (______) ______________

HOME ADDRESS: ______________________ CITY: ______________ STATE: ______ ZIP: ______

EMPLOYEE? YES ☐ NO ☐ TITLE: ______________ DEPT: ______________ WORK PHONE: (______) ______________

NAME OF WITNESS: ______________________ HOME PHONE: (______) ______________

HOME ADDRESS: ______________________ CITY: ______________ STATE: ______ ZIP: ______

EMPLOYEE? YES ☐ NO ☐ TITLE: ______________ DEPT: ______________ WORK PHONE: (______) ______________

MEDICAL PROVIDER

NAME OF CLINIC/HOSPITAL/PHYSICIAN: ______________________________ PHONE: ______________

IF NOT A DESIGNATED PROVIDER, PLEASE COMPLETE THE FOLLOWING -

ADDRESS: ______________________ CITY: ______________ STATE: ______ ZIP CODE: ______________

SIGNATURE OF SUPERVISOR/MANAGER COMPLETING REPORT

______________________________ ______________________________
Supervisor/Manager Name - Printed Phone

X______________________________ ______________________________
Supervisor/Manager Signature Date

WITNESS STATEMENT

Fax or Email this completed form to *FAS (972) 930-9479 or CLAIMS@FASTPA.COM*

EMPLOYER INFORMATION: ______________________________

ADDRESS: ______________ City: ______________ State TX Zip: __________

PHONE: ( ) __________ FAX: ______________ Policy# __________

NAME OF WITNESS ______________________ HOME PHONE ______________

HOME ADDRESS ______________________ CITY ______________ STATE ___ ZIP ______

TITLE ______________ DEPT. ______________ WORK PHONE ______________

DATE OF INCIDENT ______________ TIME OF INCIDENT ______________ A.M. _____ P.M. _____

THIS STATEMENT CONCERNS MY KNOWLEDGE OF THE ALLEGED INCIDENT.

1. NAME OF INJURED EMPLOYEE: ______________________________
2. IF NOT EMPLOYEE, REASON FOR PRESENCE AT LOCATION: ______________________________
3. ARE YOU RELATED TO INJURED EMPLOYEE? ______________ HOW? __________
4. HOW LONG HAVE YOU KNOWN THIS EMPLOYEE? ______________________________
5. PLEASE EXPLAIN IN DETAIL WHAT YOU KNOW ABOUT THIS INCIDENT: (NAME SPECIFIC INDIVIDUALS, OBJECTS OR EQUIPMENT)
6. DID YOU ACTUALLY SEE THE INCIDENT? ________ IF NOT, HOW DID YOU HEAR ABOUT IT? ______________
7. DO YOU KNOW OF ANY OTHER INJURY, INCIDENT OR ILLNESS THAT THIS EMPLOYEE HAS HAD? ________ IF SO, EXPLAIN: ________
8. GIVE THE NAMES AND ADDRESSES OF ANY OTHER PERSONS WHO MIGHT KNOW ABOUT THIS INCIDENT:
9. ADDITIONAL COMMENTS: ______________________________

I certify that the foregoing statements and answers on this form are complete and true, and that no information has been omitted.

Witness: ______________________ Verified by: ______________________
Signature Signature

Date: ______________________ Date: ______________________

Translated By (If Applicable): ______________________ Date: ______________

Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

MEDICAL TREATMENT AUTHORIZATION

THIS REPORT IS TO BE COMPLETED IN ITS ENTIRETY BY THE EMPLOYER
Fax or Email this completed form to *FAS (972) 930-9479* or CLAIMS@FASTPA.COM

EMPLOYER INFORMATION: ______________________________

ADDRESS: ______________________ City: ______________________ State TX Zip: ______________

PHONE: ( ) ______________ FAX: ______________________ Policy# ______________

INJURED EMPLOYEE: ______________________ **Social Security Number:** ______________________

To: Approved Provider

The above referenced employee has reported sustaining an occupational injury/illness related to his or her employment. You are authorized to provide medically necessary treatment and/or prescription services for conditions related to the reported injury/illness.

Type of Injury ____

Your charges for medically necessary services will be paid directly by the Employer. To facilitate prompt payment, submit your billing document and a copy of the Report (physicians only) to:

FAS
P O BOX 2309
Addison, Texas 75001

Treatment and billing inquiries should be directed to *FAS, Inc.* at (866) 930-9493. For authorization to release medical records and other information relating to the above employee's occupational injury/illness, refer to Medical Records Release Authorization.

❒ Drug /❒ Alcohol **Screen Required ❒ Yes ❒ No**

If the above box is checked ***YES***, the employee is required to submit to a drug/alcohol screen which is only for the *initial* examination and emergency treatment of the injury noted above. Please conduct a drug/alcohol screen for your panel of controlled substances and alcohol, in addition to treating the occupational injury/illness. The results of the drug/alcohol screen must be reported only to the *Employer*.

____
Supervisor/Manager Name - Printed

X______________________________________ ______________________
Supervisor/Manager Signature Date

PHYSICIAN'S REPORT OF EMPLOYEE INJURY

Please be advised that this employer does not carry workers' compensation insurance. If it becomes necessary to refer to another doctor for treatment or opinion, please furnish such information to us prior to the referral for further authorization. All bills for authorized medical treatment or any inquiries concerning authorization for treatment should be directed to:

Attn: FAS, Inc.
P O BOX 2309
Addison, TX 75001-2309

Phone (866) 930-9493
Fax (972) 930-9479
EMAIL: *CLAIMS@FASTPA.COM*

EMPLOYER INFORMATION: ______________________________

ADDRESS: ______________________ City: ______________ State TX Zip: __________

PHONE: (   ) __________ FAX: ______________________ Policy# ______________

Name of Injured Employee: ______________________________

1. Date of injury: __________________ Date first treatment rendered: __________________
2. Description of incident: ______________________________
3. Initial complaints: ______________________________
4. Diagnosis: ______________________________
5. Nature, extent, degree, body location of injury: ______________________________
6. Treatment prescribed and prognosis: ______________________________
7. Medication prescribed: ______________________________
8. Probable length of hospital confinement: (if applicable) ______________________________
9. X-rays taken ☐ Yes ☐ No If yes, results: ☐ Positive ☐ Negative ______________________________
10. Lab test ☐ Yes ☐ No Describe procedure and results: ______________________________
11. Was there any evidence of a prior or pre-existing injury or illness? ☐ Yes ☐ No If yes, what condition and to what extent may it contribute to incapacity or recovery? ______________________________
12. In an effort to help employees return to work after an injury/illness more quickly, a limited duty program is available.

This Employee
☐ May return to work today without restrictions
☐ May return to work today with restrictions as indicated below for ______ days
☐ May not return to work until ____________________

13. If restrictions are required on or off the job, please indicate below:

☐ No standing over ___ hours
☐ No work requiring depth perception/driving
☐ No reaching over shoulder height
☐ No use R/L hand/upper extremities
☐ No climbing over ___ hours
☐ No pushing/pulling over ___ lbs.
☐ Keep wound clean, dry ___ days

☐ No lifting over ___ lbs.
☐ No stooping/bending/twisting
☐ No walking over ___ hours
☐ No weight-bearing R/L foot
☐ Must use crutches/splint
☐ No operation of machines/equipment
☐ No exposure to (specify, e.g. dust, chemical) ____________

14a. Released to restricted duty: ____________, 20_____. 14b. Released to regular duty: ______________, 20____

15. Will Employee require further medical treatment? ☐ Yes ☐ No If yes, date of next appointment ______________________, 20_____

16. Comments: ______________________________

17. SIGNATURE OF PHYSICIAN; including degrees or credentials:
(I certify that the statements apply to this bill and are made a part thereof.)

SIGNED DATE

18. PHYSICIAN'S ADDRESS, ZIP CODE & PHONE:

PIN# GRP#

MEDICAL RECORDS RELEASE AUTHORIZATION

THIS REPORT IS TO BE COMPLETED IN ITS ENTIRETY BY THE EMPLOYEE
Fax or Email this completed form to *FAS (972) 930-9479 or CLAIMS@FASTPA.COM*

EMPLOYER INFORMATION: ____

ADDRESS: ______________________ City: ________________ State TX Zip: ________

PHONE: (____) __________ FAX: ______________________ Policy# ____________

I hereby authorize __________________________[name of physician, hospital or health care provider] **to furnish to Freeman Administrative Solutions, Inc., its employees, agents, and authorized representatives (hereafter individually and collectively referred to as "FAS"), any and all of my medical records and related information pertaining to my care and treatment as the result of my injury, illness, and/or claim for benefits. The medical records and related information includes, but is not limited to, medical histories, reports, charts, notes, letters, x-rays, films, MRIs, CT scans and reports, itemized bills with treatment codes, insurance and claim records, correspondence, payments, consultations, examinations, prescriptions, diagnoses, tests, and treatments.**

I understand that this information is being obtained to assist in the evaluation of my claim for benefits.

I understand that this information may be used to adjust, describe, or report matters about my care and treatment to persons entitled to receive this information.

I understand that I may revoke this authorization at any time by sending written notice to FAS except to the extent that FAS and ____________________________ **[name of physician, hospital or health care provider]** have taken action in reliance on this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to further disclosure and no longer protected by the federal health information privacy regulations. However, FAS will take precautions to maintain the confidentiality of the information disclosed pursuant to this authorization. I hereby release FAS from any liability or loss due to the release of any such information.

Nothing contained herein shall affect the treatment, payment, enrollment, or eligibility for benefits in accordance with all applicable laws.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction. A photocopy of this authorization shall have the same validity as the original.

______________________________ ______________________

Signed **Date**

Name ____________________________ SSN# ________________________

Address __________________________ Telephone (______) ____________

______________________________ ______________________________

Representative (if applicable) Relationship or Authority of Representative

Decline Medical Treatment Form

Fax or Email this completed form to *FAS (972) 930-9479 or CLAIMS@FASTPA.COM*

EMPLOYER INFORMATION: ________________________________			
ADDRESS: ____________________	City: ______________	State TX	Zip: __________
PHONE: ( ) ____________	FAX: ____________________	Policy#__________	

I ______________________________choose to decline medical treatment that has been offered to me for an injury that was sustained on______________________. I am aware that by declining medical treatment at this time, that my employer, ______________________ will not be responsible for any medical expenses or lost wages unless specifically approved by ________________________________.

Employer

____

Employee

____

Employer Representative

____

Date