**Using this Template**

The following template can be used to help your organization develop a written Select Provider Program, in which you can designate a specific or preferred physician or set of physicians for your employees to use for instances of workplace injuries. This template **cannot** be used as is – you must customize the template to meet the needs of your organization and your state laws. We have made this template easy for you to customize by adding visual prompts that identify where your input is needed. These are identified by yellow highlighted, red text in the template. You may also change any of the text in the template to meet your organization’s needs – for example, department names, job titles and listed responsibilities and procedures.

*Example:*

<COMPANY NAME>

Select Provider Program

becomes

XYZ Company

Select Provider Program

To remove the colored highlighting from your text, left click and drag your mouse over the yellow text and click on the highlighter button from the Font menu. To change the font color to black, select the text and click on the font color button.



To aid you in understanding the need to customize your program, several “Check Your Understanding” text boxes are also included throughout the template. After reading the information in the text box and adding the required information into the template, you may simply right click on the cross arrow box and select “cut.”

**<COMPANY NAME>**

***Disclaimer.*** *This sample safety program template cannot be used as is. You must customize the template to meet the needs of your organization. EMC does not guarantee that this template is or can be relied on for compliance with any law or regulation, assurance against preventable losses, or freedom from legal liability. We make no representations or warranties of any kind whatsoever either express or implied, in connection with the use of this template. EMC will not be liable for your use of the template as customized by you. All safety programs and policies, including this template and the information you supply to complete it, should be reviewed by your legal counsel and/or risk management staff.*

**Select Provider Program**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Check Your Understanding.*** A common goal of every organization’s safety program is to prevent workplace injuries. But, when an injury does occur, its ultimate cost can be controlled through injury management tools such as return to work programs and the use of designated or preferred medical providers. The Select Provider Program through EMC Insurance can assist you in establishing a designated or preferred provider for your organization. This program is offered to EMC workers’ compensation policyholders at no cost.Knowing what to do when an injury is first reported is key to controlling workers’ compensation costs. Our program’s structure helps you take control during the first 24 to 48 hours of a workers’ compensation claim by:

|  |
| --- |
| * Providing initial employee reporting procedures for a work-related injury or illness
 |
| * Collecting accurate information on the injury or illness
 |
| * Assisting employees in finding prompt, appropriate and quality medical care
 |
| * Reporting the injury to EMC claims adjusters in a timely, well-documented manner
 |
| * Using a preferred provider organization (PPO) facility/provider when possible
 |

EMC has identified medical providers throughout the country that provide quality medical care while maintaining excellent lines of communication among all parties. Increased communication, efficient procedures and prompt delivery of medical care can help your injured employees return to work faster. These outcomes can create greater employee satisfaction after a claim and improve the employer-employee relationship while reducing administrative headaches for your organization.EMC is ready to help your organization take control of workers’ compensation costs by setting up a Select Provider Program at your organization. For more information, contact your independent insurance agent, local EMC loss control representative or email claims.spp@emcins.com.  |

**Purpose**

The purpose of this program is to ensure that employees of <Company Name> receive prompt, quality medical attention for their work-related injuries and illnesses. This program allows <Company Name> to manage our workers’ compensation claims through the use of standardized procedures. This program assures that we have good reporting, prompt, quality medical care, and excellent communication between the injured employee, the employer, the designated/preferred physician, and the workers’ compensation claims adjuster.

**Scope**

This policy applies to all employees at <Company Name>. The Program Administrator is responsible for all program management and recordkeeping requirements.

|  |
| --- |
| ***Check Your Understanding.***  ***IMPORTANT -*** Each state’s laws differ regarding the extent that an employer can direct employee’s healthcare and providers. You should consult your organization’s legal counsel or your state workers’ compensation board to determine the level and extent this program can be implemented. |

**Program Responsibilities**

**Management.** The management of <Company Name> is committed to the overall injury management and workers’ compensation program. Management supports the efforts of the Program Administrator by pledging leadership support for this program.

|  |
| --- |
| ***Check Your Understanding.*** Although the term “Program Administrator” is used throughout this document, it does not need to be an official title or position at your organization. This person may be a Safety Director, Human Resource Manager, or even the company owner in a smaller organization. The term is simply used to identify the person who is responsible for reporting and managing workers’ compensation injuries in the workplace. |

**Program Administrator.** The Program Administrator will report directly to upper management and be responsible for the program. The Program Administrator shall:

* Post all related materials (***Appendix A***) on the company electronic bulletin board, in all break rooms and outside the HR office.
* Train all employees regarding their roles and responsibilities under the program, including how and when to properly complete an Employee’s Work Injury Report. (***Appendix C***)
* Obtain and maintain employee signatures related to the distribution of program materials (***Appendix B***). All signed materials will be kept in the employee’s HR folder.
* Train supervisors and employees on the listed items annually or when employees are newly assigned to the role or responsibility. Training will be documented in the Employee Acknowledgement Form. (***Appendix B***)

 **Supervisors.**

1. Purpose and details of the Select Provider Program
2. Proper completion of the Supervisor’s Investigation Report (***Appendix D***)
3. Determining available transitional work assignments
4. Monitoring returning injured employees and keeping them within restrictions prescribed by their physician

 **Employees.**

1. Purpose and details of the Select Provider Program
2. Proper completion of the Employee’s Work Injury Report (***Appendix C***)
3. How to report any work restrictions prescribed by their physician
4. How to report any difficulties with performing transitional duties assigned by their supervisor
* Complete <state’s> first report of injury and send to your local EMC agent for all injuries and illnesses.
* Communicate with injured employees, medical providers and the workers’ compensation claims adjuster.
* Work with supervisors and injured employees to review any restriction information received from the medical provider and assign appropriate transitional work, if available, when the employee is released.

**Supervisors.** Supervisors are required to:

* Obtain immediate medical attention for the injured employee. Call 911 if required. If incident is a non-emergency, call the physician or medical facility prior to the employee’s arrival, alert the medical staff of the injury/illness and approximate arrival time.
* Report job-related injuries and illnesses to the Program Administrator.
* Complete a Supervisor’s Investigation Report for every injury. (***Appendix D***)
* Work with the Program Administrator and the injured employee to review information received from the medical provider and determine if appropriate transitional work is available.
* Work with the Program Administrator to monitor the injured employee’s progress to ensure that restrictions are carefully followed and assist to resolve any difficulties.

**Employees.** An employee who is injured at work must immediately report the incident to their supervisor. Additionally, employees must:

* Complete the Employee Work Injury Report as soon as possible. (***Appendix C***)
* Work with their supervisor and the Program Administrator to review information received from the medical provider and determine if appropriate transitional work is available.
* Immediately report any difficulties with performing assigned work to their supervisor.

**Selected Physicians and Medical Facilities**

The occupational medical physicians listed below have agreed to become <Company Name’s> select provider for non-life threatening injuries occurring at work.

<CLINIC

123 4th Street

Anywhere, USA 50505

(555) 555-5555>

These physicians can provide <Company Name> employees with appropriate and convenient care. They have extended hours of <7AM to 7PM Monday- Saturday> for appointments and fully support our return to work program. They are a member of the company’s already established health care plan’s Preferred Provider Organization (PPO) network.

The hospitals listed below may treat <Company Name’s> employees for serious and life threatening injuries occurring at work. This hospital can provide <Company Name>employees with a <level one trauma center> available 24 hours a day 7 days a week.

<MEDICAL CENTER

5678 9th Street

Anywhere, USA 50505

(555) 555-5555>

Employees who choose to be treated at medical facilities other than the select providers above may not qualify for any workers’ compensation insurance benefits and may be responsible for all medical costs related to the injury or illness.

|  |
| --- |
| ***Check Your Understanding.*** If you would like assistance identifying quality medical providers for this program in your area, please contact EMC at claims.spp@emcins.com. |

**Select Provider Program Steps**

When an injury occurs, <Company Name> will follow the steps below.

* 1. Ensure the employee gets any necessary medical care.
		1. If non-emergency medical treatment is necessary, send the employee to <Physician/Clinic, Address, Phone and Hours> with the Physician Work-Related Injury/Illness Report. *(****Appendix F****)*and the completed Physician Authorization Form for Medical Treatment *(****Appendix E****)****.***
		2. If emergency medical treatment is necessary or the injury/illness cannot wait until the clinic’s office hours, send employee to the nearest hospital or emergency care facility.
	2. Have the employee fill out the Employee Work Injury Report *(****Appendix C****)* within 24 hours of the injury. Use the Employee Work Injury Report to fill out <state’s> first report of injury.
	3. Fax the first report of injury to <Insurance Company>.
	4. Complete the Supervisor’s Accident Investigation form *(****Appendix D****)* and return to the Program Administrator within 48 hours of a work-related injury.
	5. Keep record of each injury, making sure to maintain copies of all forms. All records will be stored on <computer location>.
	6. Review the information from <Physician Name> and find appropriate transitional work for the injured employee if necessary.
	7. Keep in contact with the employee and medical provider to monitor the employee’s progress, and make sure that any restrictions are carefully followed.

**Periodic Program Review**

At least annually, the Program Administrator will conduct a program review to assess the progress and success of the program. (***Appendix G***)

**Revision History**

Revision <1 – January 2013>

**Appendix A – Program Poster**

***ATTENTION ALL EMPLOYEES***

**<Company Name>**

Workers' Compensation Medical Treatment Change

EFFECTIVE: <MM/DD/YYYY>



<Company Name> has designated the following medical clinic to treat all workplace related injuries/illnesses.

**<CLINIC**

**123 4th Street**

**Anywhere, USA 50505**

**(555) 555-5555>**

For a SERIOUS INJURY OR ILLNESS (or any treatment that should not wait until clinic hours the next day), seek immediate treatment at the nearest emergency facility or call 911. Hospitals included (but not limited to):

**<MEDICAL CENTER**

**5678 9th Street**

**Anywhere, USA 50505**

**(555) 555-5555>**

**PLEASE NOTE**

|  |
| --- |
| If you choose to be treated by any other medical facility and/or physician, you may not qualify for any workers’ compensation insurance benefits, and you may be responsible for all medical costs related to this incident. This is in accordance with <state’s> Workers’ Compensation statute. |

If you have any questions regarding this procedure, please call <Company Contact (444) 444-4444>.

**Appendix B – Employee Acknowledgement Form**

**<Company Name>**

Workers' Compensation Medical Treatment Change

EFFECTIVE: <MM/DD/YYYY>



<Company Name> has designated the following medical clinic to treat all workplace related injuries/illnesses.

**<CLINIC**

**123 4th Street**

**Anywhere, USA 50505**

**(555) 555-5555>**

For a SERIOUS INJURY OR ILLNESS (or any treatment that should not wait until clinic hours the next day), seek immediate treatment at the nearest emergency facility or call 911. Hospitals included (but not limited to):

**<MEDICAL CENTER**

**5678 9th Street**

**Anywhere, USA 50505**

**(555) 555-5555>**

**PLEASE NOTE**

|  |
| --- |
| If you choose to be treated by any other medical facility and/or physician, you may not qualify for any workers’ compensation insurance benefits and you may be responsible for all medical costs related to this incident. This is in accordance with <state’s> workers’ compensation statute. |

If you have any questions regarding this procedure, please call <Company Contact (444) 444-4444>.

|  |
| --- |
| ***I verify that I have received the <Company Name> Workers’ Compensation Medical Treatment information.*** |
|       |  |       |
| Employee’s Signature (PRINTED) |
|  |
| Employee’s Signature |  | Date  |

**Appendix C**

|  |
| --- |
| You, the injured employee, are responsible for answering all questions on the Employee's Work Injury Report accurately and in detail. This completed report should be given to the Program Administrator within 24 hours of your work-related injury. |
| **Employee Work Injury Report** |
| **Personal Information** |
| Name |       | Social Security Number |       |
| Address |       | Birth Date |       | Sex |  M [ ]  F [ ]  |
| City, State |       | Zip |       | Telephone |       |
| Married [ ]  Single [ ]  | Number of Dependents |       | Home/School |       |
| Family Physician |       | Telephone Number |       |
| Are you currently entitled to Medicare Benefits? Yes [ ]  No [ ]  | Medicare #(HICN) |  |
| Have you applied for Medicare or SSDI? Yes [ ]  No [ ]  Pending [ ]  Rejected [ ]  |
| **Employment Information** |
| Job Title |       | Employment Date |       |
| Salary/Hourly Rate |       | Hours Worked Per Day |       |
| Building Location |       | Time Work Day Begins |       |
| **Injury/Illness** |  |  |  |
| Date of Injury |       | Time of Accident |       |
| Where in the facility/job site did this injury occur? |       |
| What were you doing when injured? |       |
| How did the injury occur? |       |
|       |
| Describe the injury or illness in detail and indicate the part of the body affected. (Designate right or left if appropriate) |
|       |
|       |
| Any previous similar injury? If yes, explain. |       |
| Was this injury witnessed? If so, by whom? |       |
| Did you lose time from work? | Yes [ ]  No [ ]  | Date(s) missed |  |
| Have you returned? | Yes [ ]  No [ ]  | If yes, what was the date? |  |
| **Treatment** |
| Medical Facility |       |
| Diagnosis/Care Prescribed |       |
| **Contact** |
| When you return to work, you must call <Company Contact (444) 444-4444> |
| Employee Name(PRINTED) |  | Date |  |
| Employee’s Signature |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Appendix D**

Supervisor’s Accident Investigation Report

|  |  |
| --- | --- |
| Name of Injured Employee:      | Date:      |
| Job Title and Department:      |
| Date and Time of Injury:      | Type      of Injury: |
| Medical Treatment Center:      |
| What was the employee doing when injured? Where in the facility/job site did the accident happen? |
|       |
| Describe what happened: |
|       |
|       |
|       |
| What corrective steps will be implemented (or could be implemented) to prevent recurrence?       |
|       |
| Was the employee working at designated job? | Yes [ ]  No [ ]  |
| Is there modified duty available for the injured worker? | Yes [ ]  No [ ]  |
| Has the injured employee returned to work? | Yes [ ]  No [ ]  |
|  |  |
| Supervisor’s Signature | Date |
|  |  |
|  |  |
| Reviewed by Program Administrator | Date |

|  |
| --- |
| ***Check Your Understanding.*** The statements made in investigation reports are very important and should not contain phrases such as “Employee should be more careful.” The supervisor should make the appropriate corrective recommendations for each accident such as “Notified the appropriate employee to place caution signs in the area when floors are wet.” |

**Appendix E**

PHYSICIAN AUTHORIZATION FORM
FOR MEDICAL TREATMENT

|  |  |
| --- | --- |
| Injured Employee’s Name:       | Date:      |
| Company Name and Address: | Supervisor:      |
|  |
| **Do not use your group health membership card if this injury/illness was sustained while working or acting in an official capacity for this company.** |

The following facilities are the designated workers’ compensation treatment centers. Taking this form with you will assist the staff in your care and in processing your medical bills correctly. You should call or have someone call for you to let the physician or clinic know you are on your way for medical treatment. Be prepared to describe the nature of the injury or illness.

**<CLINIC**

**123 4th Street**

**Anywhere, USA 50505**

**(555) 555-5555>**

For a SERIOUS INJURY OR ILLNESS (or any injury requiring treatment that should not wait until clinic hours the next day) seek immediate treatment at the nearest emergency facility or call 911. Hospitals included (but not limited to):

**<MEDICAL CENTER**

**5678 9th Street**

**Anywhere, USA 50505**

**(555) 555-5555>**

**PLEASE NOTE**

|  |
| --- |
| If you choose to be treated by any other medical facility and/or physician, you may not qualify for any workers’ compensation insurance benefits and you may be responsible for all medical costs related to this incident. This is in accordance with <state’s> workers’ compensation statute. |

If you have any questions regarding this procedure, please call <Company Contact (444) 444-4444>

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Supervisor’s Signature | Date |

**Appendix F**

Physician Work-Related Injury/Illness Report

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | **PLEASE FAX IMMEDIATELY TO BOTH**: |
| Date of Service: |       |  | **<Company Name> Fax:** | **<(999) 999-9999** |
| Patient Name: |       | **EMC Insurance Companies Fax:** | **(Contact your agent for branch fax number)>** |
| Employer: |       | Notified:  [ ]  Yes  [ ]  No |

|  |  |  |
| --- | --- | --- |
| Diagnosis: |       | Is condition work related?     Yes   No |
| Treatment Plan: |       |
| Medication(s): |       |  |
| Date of most recent examination by this office: / / . The next scheduled visit is:  as needed OR / / . |
|  Month/Day/Year |
| 1.  Recommended his/her return to work with no limitations on   . |
|  Date |
| 2.  He/She may return to work on   with the following limitations: |
|  Date |
| **DEGREE** | **LIMITATIONS** |
|   **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.  **Light Work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.  **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying objects weighing up to 25 pounds.  **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.  **Very Heavy Work.** Lifting objects in excess of 100 pounds with frequent lifting and/or carrying of objects weighing 50 pounds or more. | 1. In an 8 hour work day, patient may:

|  |  |  |  |
| --- | --- | --- | --- |
| a. Stand/walk |  None |   4-6 Hours |  |
|  |   1-4 Hours |   6-8 Hours |  |
| b. Sit |   1-3 Hours |   3-5 Hours |   5-8 Hours |
| c. Drive |  1-3 Hours |   3-5 Hours |   5-8 Hours |

2. Patient may use hands for repetitive:   Single grasping  Pushing and pulling   Fine manipulation3. Patient may use feet for repetitive movement as in operating foot controls:   Yes   No4. Patient is able to:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Frequently | Occasionally | Not at all |
| a. Bend |  |  |  |
| b. Squat |  |  |  |
| c. Climb |  |  |  |

 |
| **OTHER INSTRUCTIONS AND/OR LIMITATIONS:** |
| 3.   These restrictions are in effect until   or until patient is reevaluated. |
|  Date |
| 4. [ ]  He/She is totally incapacitated at this time. Patient will be reevaluated on   . |
| Date |
| **THIS TREATMENT HAS BEEN DISCUSSED WITH THE EMPLOYEE** |
| Treating Facility Name |  |
| Please Print |
| Physician’s Signature: |   | Phone No: |  |

**Appendix G – Annual Evaluation Report**

|  |  |
| --- | --- |
| Date of Evaluation: | Evaluated By (list all present): |
| Written Program Reviewed: Yes No |
| Comments on Written Program: |
| The following specific procedures have been reviewed: |
| The following specific procedures were modified: |
| The following specific procedures were added: |
| A review of the accident reports and injury and illness reports were made: Yes No |
| The following additional expense(s) resulted from failure to use correct select provider procedures: |
| Comments: |