Welcome! Thank you for choosing Benchmark/Diamond Insurance to be your workers' compensation carrier. We are pleased with the opportunity to do business with you and eager to exceed your expectations of service. Your agent has requested that you receive this claims kit regardless of how long you have been with Benchmark/Diamond.

You will find clear instructions below on how to submit a workers' compensation claim.

How To Submit A Claim To Benchmark Administrators:

Email: send completed Notice of New Claim Form and First Report of Injury to the email address below:

Benchmark Administrators
Phone: 866-337-0891
Email: coverage@treancorp.com

Loss Prevention Contact Info:
for any claims submission questions:
Steven Sterling, PT
Email: ssterling@diamondwc.com
Cell Phone# 608-772-3414

Forms:

Notice of New Claim Form:	Your fax or email cover sheet
Form LIBC-90	Pennsylvania's First Report of Injury used to report a new claim
Employee incident form	Employee completes this document of injury
First fill card	Benchmark's prescription fill process for first pharmacy fill
Worker's Comp Posters	Notices that must be displayed at your business

NOTICE OF NEW CLAIM

EMAIL: coverage@treancorp.com **with**
"new claim—(employee name)" in the subject line

FAX: **(**314) 230-7003

FROM: **Insured:**_____
Reported By:_____
Phone:_____
Date:_____
Email:_____ **# of Pages:**____

PLEASE CHECK ONE:

- ☐ No outside medical attention (incident only/report only)
- ☐ Employee returned to work full duty
- ☐ Employee returned to work with restrictions
- ☐ Employee has been authorized off work

PLEASE ATTACH STATE FORM FOR A NEW CLAIM

- ☐ Form LIBC-90, First report of injury.

ADDITIONAL INFORMATION:

- ☐ Claim is questionable?

COMMENTS:_____

Diamond Insurance Group, Ltd.
Member Trans Continental Investment Services, Ltd.
1900 E. Golf Road, Suite 1275, Schaumburg, IL 60173 * Toll Free: (888) 643-4310, Fax: (847) 230-1381 * www.diamondwc.com

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

ELECTRONIC DATA INTERCHANGE

First Report of Injury

Transaction Title: (e.g. FROI)
Transaction Type: (e.g. Denial 04)

Jurisdictional Claim Number: (e.g.CLM-2012021312345)
Date Transaction Submitted to BWC: May 8 2012 01:30 PM

Employee Information	
First Name:	Middle Name:
Last Name:	Last Name Suffix:
Employee ID:	ID Type:
Date of Birth:	Date of Death:
Number of Dependents:	Employee Marital Status Code:
Mailing City:	
Mailing State Code:	
Mailing Postal Code:	
Gender Code:	
Mailing Primary Address:	
Mailing Secondary Address:	
Mailing Country Code:	
Phone Number:	
Date Of Hire:	
Occupation Description:	

Claim Information	
Jurisdiction Claim Number:	Jurisdiction:
Initial Date Disability Began:	Claim Type Code:
Type of Loss:	
Death Result of Injury Code:	
Claim Status Code:	
Late Reason Code:	
Accident Site County/Parish:	
Initial Return to Work Date:	
Initial Date Last Day Worked:	
Employment Status Code:	
Employer Paid Salary in Lieu of Compensation Indicator:	
Date Employer Had Knowledge of Date of Disability:	
Return to Work Type Code:	

Injury Information
Date of Injury:
Nature of Injury Code:
Time of Injury:

Injury Information
Part of Body Injury Code:
Cause of Injury Code:
Accident/Injury Description Narrative:

Denial Information
Full Denial Reason Code:
Denial Reason Narrative:

Insurer Information	
Insured Report Number:	Insured FEIN:
Insurer FEIN:	
Insured Name:	
Insured Type Code:	
Insurer Name:	

Claim Administrator Information
Claim Administrator Name:
Claim Administrator FEIN:
Claim Administrator Postal Code:
Claim Administrator Claim Number:
Claim Administrator City:
Claim Administrator State Code:
Claim Administrator Information/Attention Line:
Claim Administrator Primary Address:
Claim Administrator Secondary Address:
Claim Administrator County Code:

Employer Information	
Name:	Employer FEIN:
Physical Primary Address:	
Secondary Address:	
Physical City:	
Physical Postal Code:	
Physical Country Code:	

Employer Information
Contact Name:
Mailing Secondary Address:
Mailing City:
Mailing Postal Code:
Mailing State Code:
Mailing Country Code:
Mailing Information/Attention Line:
Policy Number Identifier:
Contact Business Phone:

DIAMOND
INSURANCE COMPANY

Employee Incident Report

Instructions: Injured worker to complete with **ALL** blanks filled in; if not applicable use NA.

EMPLOYEE

Your Name:_____ S.S.# (required):_____

Street Address:_____

City:_____ State:_____ Zip:_____

Phone #:_____ Marital Status: S☐ M☐ D☐ W☐

Children under 18 (list gender and age): _____

_____

Date of Birth: _____ Height:_____ Weight:_____

Facility Name:_____

Job Title:_____ Department:_____

Other Employment (company name(s) and type of work):_____

INCIDENT

Date of Incident:_____ Time:_____ Place:_____

What were you doing at the time of the incident?_____

_____

What happened?_____

_____

_____

Property/Equipment Involved:_____

Witness(es), if any:_____ No Witnesses: ☐

To whom did you report the injury?_____

Date you reported it:_____ Time you reported it:_____

Explain any onsite treatment received:_____

INJURY

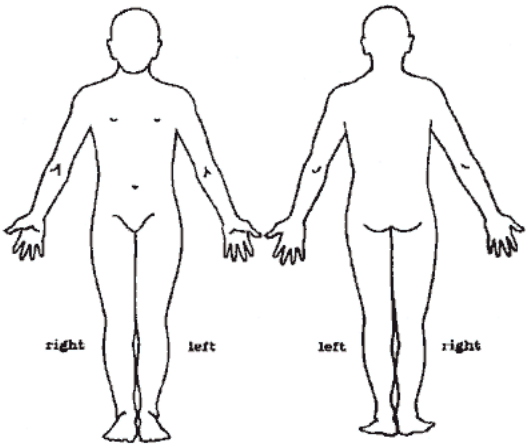
What Parts(s) of your body was injured? Describe in detail and circle the body parts on the figure on the right:

_____

_____

_____

_____



GENERAL INFO

Family Doctor:_____ Phone:_____

Address:_____

Describe any Chronic Illness (diabetes, high blood pressure, etc):

_____

Have you understood the questions you answered?_____

EMPLOYEE SIGNATURE:_____ DATE:_____

Mitchell ScriptAdvisor

Benchmark Administrators

First Fill – Temporary Prescription Card

Benchmark Administrators

Mitchell ScriptAdvisor has been selected by **Benchmark Administrators** to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply **fill in the form below** and present it at the pharmacy at the time your prescription is filled. This form should ensure that you will have NO out-of-pocket expenses when you fill your first prescription.

For your convenience, **Mitchell** ScriptAdvisor has an extensive network of retail pharmacies including major chain drug stores. For pharmacy locations, you may call our toll-free number or visit our website at **www.mitchellscriptadvisor.com** use the pharmacy locator.

Employee

- Please contact Customer Service at 866.846.9279 to request activation of your Temporary Prescription ID.
- Fill in the ID number supplied by Mitchell Customer Service along with your name on the ID card below.
- Present this sheet to the pharmacist along with your prescription.

Pharmacy

- This sheet is a Temporary Prescription ID Card for a 5 Days' Supply Fill until this individual's permanent card can be provided.
- All data needed to process this script through the Script Care Adjudication System is included in the drug card represented below.

Mitchell ScriptAdvisor

Temporary Prescription Benefit Card

SCRIPT CARE, LTD.

Member Name:

Member ID #:

Rx BIN: 004410

PCN: SCI

Questions? Contact us at 866.846.9279

This card is to be used for prescriptions related to your workers' compensation injury-related injuries covered under your insurance policy. Use of this card does not waive any limitations or exclusions for the policy. This card does not confirm coverage. To confirm eligibility or obtain specific information, please contact the Help Desk with the information from the front of this card.

mitchell

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

REMEMBER: IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY

The name, address and telephone number of your employer's workers' compensation insurance company, third-party administrator (TPA), or person handling workers' compensation claims for your company, are shown below.

Employer Name: _____ **Date Posted:** _____

IF INSURED:
(Complete all applicable spaces)

Name of Insurance Company: _____

Address: _____

Telephone Number: _____

Insurer Code: _____

IF SOMEONE OTHER THAN INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator): _____

Address: _____

Telephone Number: _____

IF SELF-INSURED
(Complete all applicable spaces)

Name of person handling claims at the self-insured: _____

Address: _____

Telephone Number: _____

Insurer Code: _____

IF SOMEONE OTHER THAN SELF-INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator): _____

Address: _____

Telephone Number: _____

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
PA Relay 7-1-1

Email
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program