amazon workers' compensation

Workers Compensation Packet

amazon FULFILLMENT

Authorization for Initial Medical Evaluation

To be completed by the Amazon site representative that is assisting the Associate in the workers' compensation process. This form is to be signed and dated by that same Amazon site representative to verify the site knowledge of the incident.

Associate Name: _____ *Date:* _____

Associate Login: _____ *Associate DOB:* ____/____/____

Date/Time of Injury: _____ *Date/Time Injury Reported:* _____

Appointment Date/Time: _____

Description of Illness/Injury: _____

_____

Name of Person(s)/Medical Provider Authorized to Provide Initial Medical Evaluation

Medical Provider Name: Xpress Urgent Care - PSL

Medical Provider Address: 672 SW Prima Vista Blvd Ste 102 Port St Lucie, FL 34983

Medical Provider Phone: 772-905-2560

Amazon Site Representative Authorizing Initial Medical Evaluation:

Printed Name: _____

Title: _____

Signature: _____

Date: _____

Amazon Contact Information:

Billing Information
Sedgwick Claims Management
PO Box 14481
Lexington, KY 40512
Phone: 800-400-0088

Workers' Compensation Appointment Attendance Verification

Name: _____
Login: _____

Date: _____ Time of Appointment: _____

Clock Out: _____ Clock In: _____ Total Time Used: _____

Appointment Type (Circle One):

Initial Evaluation Physical Therapy Follow-Up Other

Location of Medical Appointment: _____

For each appointment this card must be completed. The following needs to be completed by office staff at your appointment.

Arrival Time: _____ Departure Time: _____

Medical Provider Staff Signature: _____

While on WC it's **your** responsibility to accurately report all work hours that you miss due to WC approved medical appointments.

1st - Notify HR prior to leaving FC
2nd - Clock out to attend appointment
3rd - Return to FC, clock in, submit copy of time stamp document to HR

REPORT YOUR WORK AND MISSED WORK TIME WITH MYTIME

Workers' Compensation Appointment Attendance Verification

Name: _____
Login: _____

Date: _____ Time of Appointment: _____

Clock Out: _____ Clock In: _____ Total Time Used: _____

Appointment Type (Circle One):

Initial Evaluation Physical Therapy Follow-Up Other

Location of Medical Appointment: _____

For each appointment this card must be completed. The following needs to be completed by office staff at your appointment.

Arrival Time: _____ Departure Time: _____

Medical Provider Staff Signature: _____

amazon workers' compensation

Expectations

You are the owner of your claim.

- It is up to you to ensure Sedgwick and your site receive all necessary information and documentation throughout the life of your claim.
- Attend all scheduled appointments. If unable to attend, notify Sedgwick or Workers' Compensation POC.
- Turn in your work restrictions to your site AMCARE/Safety (WHS) after each visit.
- Turn in your attendance verification form to your Site HR Team if you are missing work to attend appointments to ensure UPT is excused.
- Forward any bills received to Sedgwick.
- Ensure you check your voicemail and personal email regularly for any updates concerning your claim.

Your Partners

You are surrounded with a team of specialists to assist and guide you through your recovery.

Workers' Compensation Team provides claim oversight and support to both internal and external parties.

Sedgwick Claims Management Services, Inc.
Responsible for all claim activities including but not limited to claim acceptance/denial, review of all medical treatment, payment of benefits such as medical care and wage replacement benefits

Human Resources (HR)
Assists you with any issues related to time coding, attendance, benefit policies and employment

AMCARE/Safety (WHS)
Manages all aspects of the work-related restrictions and placement of associates in restricted duty or TED jobs

Disability and Leave Services (DLS) Team
Responsible for accommodating work-related restrictions for sites **without** AMCARE/Safety/WHS. To initiate a Leave of Absence (LOA) if placed off work by the doctor or if the site cannot accommodate restrictions follow the options below:

Option 1: Login to https://atoz.amazon.work
Option 2: Call the ERC at 888-892-7180

My HR

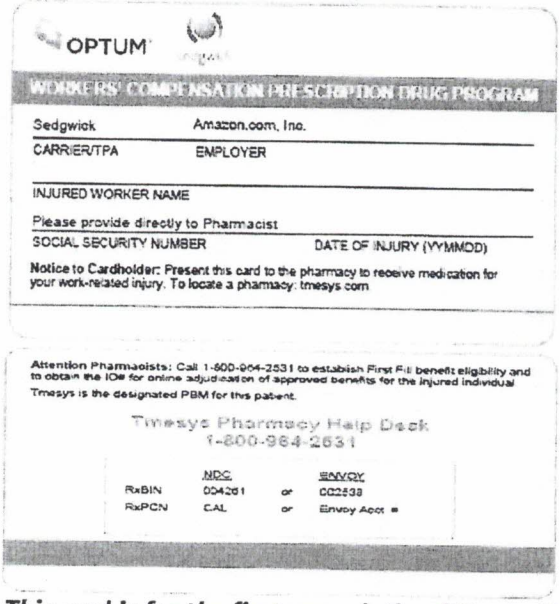
All this information and more can be conveniently found in the My Workplace category of MyHR.

https://atoz.amazon.work/myhr

OPTUM

MAKING IT EASY... To get your prescriptions filled.

Please Provide to Pharmacy:
Rx BIN: 004261 or 002538
Rx PCN: CAL or Envoy ACCT #


OPTUM

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Sedgwick | Amazon.com, Inc.
CARRIER/TPA | EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist

SOCIAL SECURITY NUMBER | DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com

Attention Pharmacists: Call 1-800-964-2531 to establish First Fill benefit eligibility and to obtain the IOI# for online adjudication of approved benefits for the injured individual. Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		ENVOY
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct #

This card is for the first prescription fill only if necessary. **A pharmacy card will be mailed directly to you.**

Helpful Resources

Claims Administrator & Billing Address:
Sedgwick Claims Management Services, Inc.
PO Box 14421, Lexington, KY 40512
844-693-0335

ASL FAQ Video:
https://broadcast.amazon.com/videos/221842

ASL Workers' Compensation Introduction Email:
https://broadcast.amazon.com/videos/549689

amazon

Healthcare Provider Request for Information (RFI) Form

Please return completed form to the site by your next scheduled shift.

PATIENT/EMPLOYEE NAME:
DATE OF BIRTH:
AMAZON SITE NAME:

TODAY'S DATE:
DATE OF NEXT APPOINTMENT:

AMAZON EMAIL:
AMAZON FAX:

Healthcare Provider: The intent of this form is to obtain information for work accommodations. This form may also be used for Workers' Compensation claims when applicable.

SECTION I: PATIENT/EMPLOYEE RETURN TO WORK STATUS

Please select current status: ☐ Work-Related ☐ Non Work-Related ☐ Undetermined

Diagnosis: _____

The associate may return to work: ☐ With NO restrictions ☐ With the restrictions listed in section II ☐ Unable to return to work at this time

Duration of restrictions listed below: Start Date_____ End Date_____ Estimated RTW Full Duty_____

SECTION II: PHYSICAL RESTRICTIONS RELATED TO ESSENTIAL JOB FUNCTIONS

Please note any physical limitations/restrictions that may interfere with performance of job duties and/or require workplace modifications. ***Blanks will be considered as N/A.***

Job Task Please indicate side restriction applies to by circling left **(L)**, right **(R)**, or both **(B)**.	**Time** Please indicate the maximum amount of time in hours the patient/employee is allowed to perform each task.							
	Up to 5 lbs.	**Up to 10 lbs.**	**Up to 15 lbs.**	**Up to 20 lbs.**	**Up to 30 lbs.**	**Up to 40 lbs.**	**Up to 50 lbs.**	**Permanent Limitation**
Lift/Carry: **(L, R, B)**								☐
Push/Pull: **(L, R, B)**								☐

Job Task	**Time** Please indicate the maximum amount of time in hours the patient/employee is allowed to perform each task.	
Repetitive Motion of Hands: **(L, R, B)**		☐
Simple Hand Grip (<15 lbs.): **(L, R, B)**		☐
Forceful Hand Grip (>15 lbs.): **(L, R, B)**		☐
Overhead Reach: **(L, R, B)**		☐
At Shoulder Reach: **(L, R, B)**		☐
Below Shoulder Reach: **(L, R, B)**		☐
Head/Neck Rotation (> 20°): **(L, R, B)**		☐
Bend/Twist		☐
Kneel		☐
Crawl		☐
Squat		☐
Sit		☐
Stand		☐
Walk		☐
Climb Stairs (5 or more steps)		☐
Climb Step Stool (4 or less steps)		☐

1	Are there any weekly time limitations? (ex. ≤40 hrs.) ☐YES ☐NO If YES, please explain limited hours: _____hours/day _____hours/week
2	Does the patient/employee have any limitations or restrictions that may interfere with Safety Sensitive job duties such as operating a delivery van, forklift, reach truck, scissor lift, or truck: ☐YES ☐NO If YES, please describe limitations or restrictions: _____
3	Does patient/employee have any limitations that would prevent wearing safety shoes/steel toed boots/composite shoes, etc.? ☐YES ☐NO If YES, please describe limitations: _____
4	Was patient/employee prescribed medical equipment? (i.e. rigid brace, crutches, boot, etc.) ☐YES ☐NO If YES, please list: _____
5	Did the patient/employee undergo a procedure or receive other medical treatment? (e.g., stitches, surgical glue, etc.) ☐YES ☐NO If YES, please list: _____
6	Was patient/employee prescribed medication or directed to take OTC medication at prescription strength as a result of injury? ☐YES ☐NO If YES, please list medication and dosage: _____
7	Was patient/employee referred to a specialist or other medical practitioner? (i.e. physical therapy, chiropractor, etc.) ☐YES ☐NO If YES, please list: _____
8	**Home** care instructions provided (e.g., exercises, stretches, ice, heat, etc.)? _____
	At work care instructions provided including frequency and duration (e.g., ice, heat, etc.)? _____

SECTION III: HEALTHCARE PROVIDER SIGNATURE AND CONTACT INFORMATION

HEALTHCARE PROVIDER NAME/TITLE _____ HEALTHCARE PROVIDER SIGNATURE _____ DATE _____

ADDRESS _____

CITY, STATE _____ ZIP _____ PHONE _____ FAX _____

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. This document is not intended for US OSHA Recordkeeping purposes.