PLAN NAME:BC/BS GROUP #: 32134 BIN#: 004915

AUTHORIZATION FOR INITIAL TREATMENT

County Risk Services, Inc.

Third Party Administrator for ACCA Self-Insurers Fund

Third Party Administrator For ACCA Association of County Commissions of Alabama

TO BE COMPLETED BY EMPLOYEE

If you desire program benefits, read and sign below. Benefits will not be authorized without your signature.

I hereby authorize any physician, health care professional, hospital, or other medical care facility to provide my complete health care records to representatives of ACCA WCSIF (Association of County Commissions of Alabama Self-Insurers Fund) and/or its agents regarding my health and any treatment rendered. I authorize representatives of ACCA WCSIF and/or its agents to examine any and all records including but not limited to: all history and physical examinations; progress notes; physicians' notes; lab reports; x-ray, MRI, CT scans, myelograms and all other diagnostic procedure reports; all consultation reports and records, in-patient and out-patient facility records; operative reports; payment records; prescribed medications; and all notes, correspondence and records of any kind.

In addition, I authorize the release of information relating to (1) communicable diseases such as hepatitis and the human immunodeficiency virus (HIV); (2) substance abuse treatment records; and (3) all mental health treatment records.

The purpose for disclosure of these records is to allow ACCA WCSIF to evaluate my medical history and injuries in this claim and to administer benefits I may be eligible for under the ACCA WCSIF program. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original. This Authorization for Release of Health Information is valid for one year from the date of my signature.

I understand that I may revoke this authorization by sending a signed, written notice to ACCA WCSIF and to the healthcare provider(s) authorized to disclose my health information pursuant to this document. However, I also understand that any revocation will be effective only to the extent that action has not already been taken in reliance of this authorization.

By refusing to sign or revoking this authorization, I understand that ACCA WCSIF will be unable to provide benefits under this program as medical records are required.

Employee Signature:_____ Date:_____

EMPLOYEE: Give completed copy to your supervisor immediately after receiving treatment.

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TO BE COMPLETED BY SUPERVISOR

Employee Name:_____ S.S. #:_____-_____-_____

Date of Injury:_____ Department:_____ Division/Facility:_____

Description of Accident/Injury:_____

_____

Supervisor Signature:_____ Date:_____

EMPLOYEE: When completed by Supervisor & Physician – immediately email or fax to CRS, Inc. at workerscompclaims@countyrisk.org or (334) 394-3244

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TO BE COMPLETED BY PHYSICIAN

Diagnosis:_____

_____

Work Status: _____ May return to full duty

_____ Out of work for _____ days, then return to work with restrictions (see below)

_____ May return to work with the following restrictions for _____ days:

Activity Restrictions:_____

_____

Physician Name (please print):_____ Return Appointment Date:_____

Physician Signature:_____ Date:_____

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TO BE COMPLETED BY EMPLOYEE AFTER BEING SEEN BY PHYSICIAN

I understand and agree to the recommended activity restrictions and follow up instructions. I agree I will not perform any activities outside the limitations either at work or home.

Employee Signature:_____ Date:_____

INSTRUCTIONS FOR SUBMITTING CLAIM FOR PAYMENT

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PHYSICIAN'S OFFICE:

1. Immediately email or fax this form to CRS, Inc. at workerscompclaims@countyrisk.org or (334) 394-3244.
2. Give original to employee. Instruct employee to take original back to the employer. Keep a copy in the employee's chart.
3. Claim filing:
    A. For authorization and timely payment, office notes must be sent to CRS, Inc.:
    Fax to (334) 394-3244 or mail to CRS, Inc.: P. O. Box 589, Montgomery, AL 36101-0589.
    B. Send claim to:
    Please file electronically to Blue Cross/Blue Shield (Group 32134) - Use the WRI prefix with the employee's social security number. (Do not use the EIB number)
    NOTE: DO NOT CHARGE CO-PAYS OR DEDUCTIBLES.

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PHARMACY:

Send claim to Blue Cross/Blue Shield of Alabama. All prescriptions must be filed electronically with BC/BS by using the WRI prefix and the employee's social security number. (Do not use the EIB number) Please use BIN# 004915, group number 32134 and in the PCN field use WRI#. ACCA WCSIF does have a Formulary and some drug classes require prior approval before BC/BS will approve the prescription under WRI. Charges filed manually, or through third party billing companies, will not be reimbursed. If you are unable to obtain approval or confirmation, please contact ACCA WCSIF/CRS, Inc. at (888) 608-2009 (toll-free) or (334) 394-3232 for assistance.