



We take claims personally.

Non-CA Claims Kit



REPORT A CLAIM

- **Internet:** www.athensadmin.com/reportclaim
User name: pacwest
Password: pacwest
- **Phone:** 866-308-4446
- **Email:** reportclaim@athensadmin.com

Have the following information ready *before* calling to report a new claim:

- **Employer's:**
 - Name
 - Address
 - Federal Employment Identification Number (FEIN)
- **Injured Employee's :**
 - Name
 - Address
 - Telephone Number
 - Social Security Number
 - Date of Birth
 - Marital Status
 - Number of Dependents
 - Length of Employment
 - Gross Weekly Salary & Hours
- **Description of Accident**
- **Description of Injury**
- **Name of Witness and/or First to Arrive At Accident Scene**

SAMPLE E-REPORTING FORM

EMPLOYER			
INSURED NAME [REDACTED]		FEDERAL TAX ID [REDACTED]	LOCATION CODE [REDACTED]
ADDRESS [REDACTED]		UNEMPLOYMENT ID [REDACTED]	D/B/A NAME [REDACTED]
CITY [REDACTED]	STATE ZIP [REDACTED]	ADDRESS [REDACTED]	
COUNTY [REDACTED]		CITY [REDACTED]	STATE ZIP [REDACTED]
SIC/NAICS CODE [REDACTED]			
EMPLOYEE			
FIRST NAME [REDACTED]	MIDDLE NAME [REDACTED]	LAST NAME [REDACTED]	EMPLOYEE NUMBER [REDACTED]
ADDRESS [REDACTED]		SSN [REDACTED]	PHONE NO. [REDACTED]
CITY [REDACTED]	STATE ZIP [REDACTED]	DATE OF BIRTH [REDACTED]	<input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE
COUNTY [REDACTED]		OFFICER / PARTNER <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	MARITAL STATUS [REDACTED]
REGULAR DEPARTMENT OR DIVISION [REDACTED]		DATE OF HIRE [REDACTED]	STATE OF HIRE [REDACTED]
OCCUPATION [REDACTED]		MINOR'S WORK CERTIFICATE NUMBER (IF UNDER 18) [REDACTED]	
WAGE RATE [REDACTED]		NCCI CLASS CODE [REDACTED]	
PER [REDACTED]	AVERAGE HOURS/DAY [REDACTED]		AVERAGE DAYS/WEEK [REDACTED]
OCCURRENCE			
PLACE OF ACCIDENT OR OCCURRENCE [REDACTED]		DATE OF INJURY / ILLNESS [REDACTED]	DID EMPLOYEE LOSE ONE OR MORE DAYS OF WORK? <input type="checkbox"/> YES
CITY [REDACTED]	STATE ZIP [REDACTED]	TIME OF OCCURRENCE [REDACTED]	LAST DATE WORKED [REDACTED]
COUNTY OF INJURY [REDACTED]	FILING STATE [REDACTED]	TIME WORKDAY BEGAN [REDACTED]	FIRST DATE OF DISABILITY [REDACTED]
EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNKNOWN		FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
RETURNED TO WORK? <input type="checkbox"/> YES: DATE [REDACTED]		DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
<input type="checkbox"/> NO <input checked="" type="checkbox"/> UNKNOWN		DATE EMPLOYER NOTIFIED [REDACTED]	
PERSON NOTIFIED [REDACTED]			
DESCRIBE NATURE OF INJURY OR ILLNESS IN DETAIL (include part of body affected, e.g., strain to lower back, fractured arm, lead poisoning.) [REDACTED]			
EMPLOYEE'S WORK ACTIVITY AT TIME OF INJURY (e.g., loading truck, typing, assembling product) [REDACTED]			
DESCRIBE EMPLOYEE'S ACTIVITIES WHEN INJURY OCCURRED WITH DETAILS OF HOW EVENT OCCURRED (Who was involved, tools, machinery, employee's actions, etc.) [REDACTED]			
FATALITY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
DATE OF DEATH [REDACTED]		WERE THEY USED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
MEDICAL INFORMATION			
SELECT TYPE OF TREATMENT	<input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> HOSPITALIZED <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> EMERGENCY ROOM <input type="checkbox"/> IN-HOUSE / FIRST AID <input checked="" type="checkbox"/> UNKNOWN	FACILITY NAME [REDACTED]	TELEPHONE [REDACTED]
		ADDRESS [REDACTED]	PHYSICIAN'S NAME [REDACTED]
		CITY [REDACTED]	STATE ZIP [REDACTED]
WITNESSES (NAME & PHONE NO.) [REDACTED]			
DATE COMPLETED [REDACTED]	REPORTED BY [REDACTED]	TITLE [REDACTED]	PHONE NUMBER AND EXT. [REDACTED]

FIND A HEALTHCARE PROVIDER

Athens and REM has selected a superior multi state industry provider, CorVel, for Preferred Provider Organization (PPO) services. This partnership provides superior care to injured employees while controlling medical costs. In-network providers have been selected based on demanding criteria, including quality, range of services, price and location; they are re-credentialed on a regular basis.

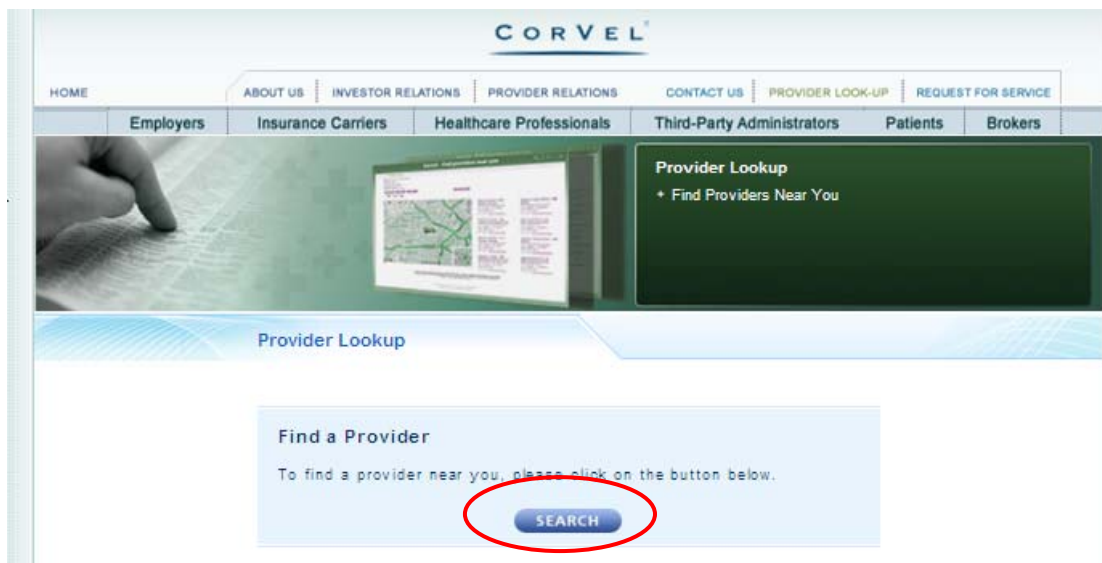
Find a provider:

Step 1: Visit www.corvel.com

Step 2: Click “Provider Lookup” on the top menu



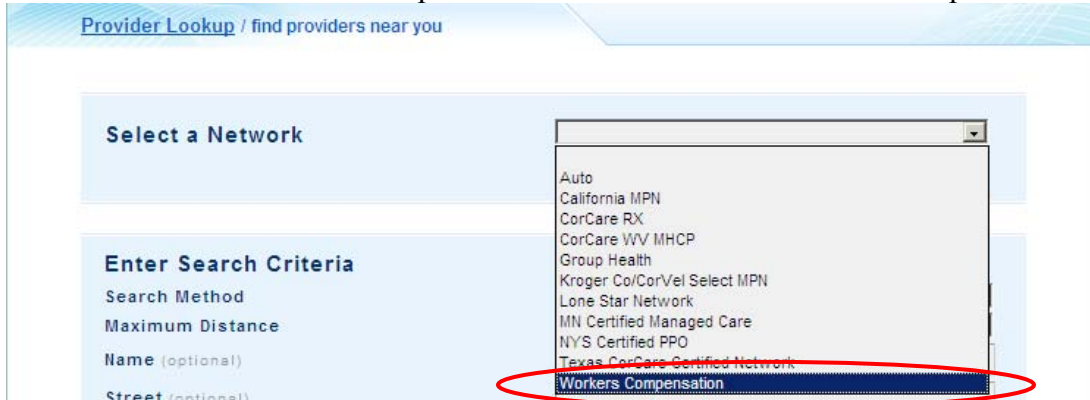
Step 3: Select “Search” from the “Find a Provider Panel” Menu



FIND A HEALTHCARE PROVIDER

Step 4:

A. Select “Workers Compensation” in the “Select a Network” Dropdown Menu



Provider Lookup / find providers near you

Select a Network

Enter Search Criteria

Search Method

Maximum Distance

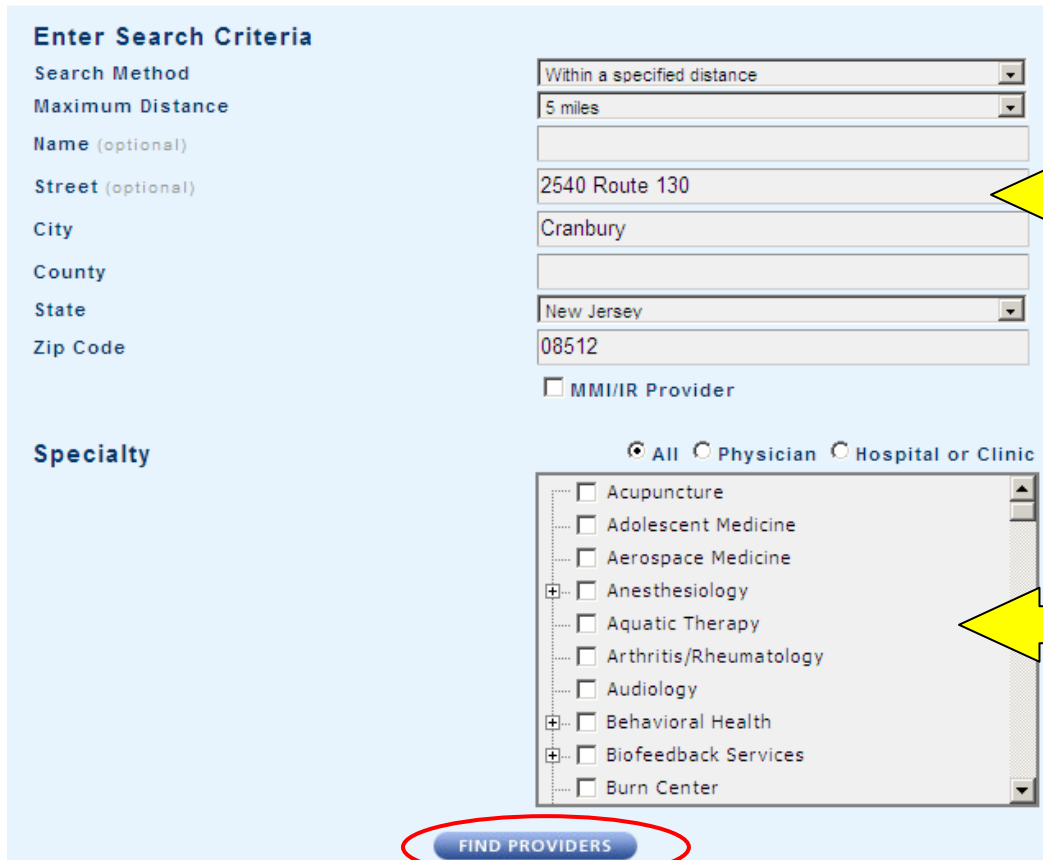
Name (optional)

Street (optional)

Auto
California MPN
CorCare RX
CorCare WV MHCP
Group Health
Kroger Co/CorVel Select MPN
Lone Star Network
MN Certified Managed Care
NYS Certified PPO
Texas CorCare Certified Network
Workers Compensation

B. Enter Your Address and Select Appropriate Distance and Specialty

C. Click “Find Providers”



Enter Search Criteria

Search Method: Within a specified distance

Maximum Distance: 5 miles

Name (optional):

Street (optional): 2540 Route 130

City: Cranbury

County:

State: New Jersey

Zip Code: 08512

MMI/IR Provider

Specialty

All Physician Hospital or Clinic

Acupuncture
 Adolescent Medicine
 Aerospace Medicine
 Anesthesiology
 Aquatic Therapy
 Arthritis/Rheumatology
 Audiology
 Behavioral Health
 Biofeedback Services
 Burn Center

FIND PROVIDERS

FRAUD REPORTING

Insurance fraud costs Americans billions of dollars each year.

If you suspect **Workers Compensation Fraud** or **Medical Fraud** contact the **National Crime Bureau**:

1-800-TEL-NICB (1-800-835-6422)
www.nicb.org

Your call is **free**. Your call can be **anonymous**. You could be eligible for a **reward**.



How to Report a *New Claim*

Reference Guide for Workers' Compensation

Phone: 866-308-4446

Fax: 877-263-4389

Internet

www.athensadmin.com/reportclaim

Username: pacwest

Password: pacwest

Email:

reportclaim@athensadmin.com

Mail

P.O. Box 696

Concord, CA 94522

To inquire about an open claim, please contact your examiner directly by using the Claims Team Reference Sheet. If you do not know who your examiner is please contact your Account Manager, who is also listed on the Claims Team Reference Sheet.



Athens/Leavitt/Hartford Claims Team (as of 11/3/12)

California Account Manager Non-California Account Manager		Jamie Sanderson Cindi Rickert	925-826-1127 610-841-2877	jsanderson@athensadmin.com cynthia.rickert@tristargroup.net	
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	Chasity Langley 949-648-5893 clangley@athensadmin.com	Ashley Unzelman 949-648-5846 aunzelman@athensadmin.com	Ashley Unzelman 949-648-5846 aunzelman@athensadmin.com		
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AZ, NV	Edgar Castro (New Losses A-M) 800-347-7734 edgar.castro@tristargroup.net	Laura Glavich (New Losses N-Z) 866-312-6095 laura.glavich@tristargroup.net	Angelica Carmona 714-579-2500 x2554 714-579-2507 fax angelica.carmona@tristargroup.net	Michael Imbriano 720-926-0222 x 3433 888-538-9847 michael.imbriano@tristargroup.net	Michael Imbriano 3230 East Imperial Highway, Suite 300 Brea, CA 92821
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NM <small>Keenan & Associates</small>	Andrea Kubler 505-291-4974 akubler@keenan-assoc.com		Andrea Kubler 505-291-4974 akubler@keenan-assoc.com	Michael Imbriano 888-538-9847 michael.imbriano@tristargroup.net	Michael Imbriano 3230 East Imperial Highway, Suite 300 Brea, CA 92821