Berkley Risk
| a Berkley Company

# Welcome to Berkley Risk!

## National Workers Compensation Information

222 S 9th Street, Suite 2700 Minneapolis, MN 55402
berkleyrisk.com

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# Welcome to Berkley Risk!

Berkley Risk is very pleased to be your Workers Compensation administrator/insurance carrier. Berkley Risk is a member company of W. R. Berkley Corporation, a Fortune 500 holding company. W. R. Berkley Corporation is one of the nation's premier commercial lines property casualty insurance providers with an A. M. Best A+ rating. Berkley Risk has always been built on a foundation of superior claims service and results; our claims team averages 20+ years of experience and everyone is empowered to resolve issues immediately. Our customer-first culture creates a quality experience for agents and insureds – in person or on-demand, online.

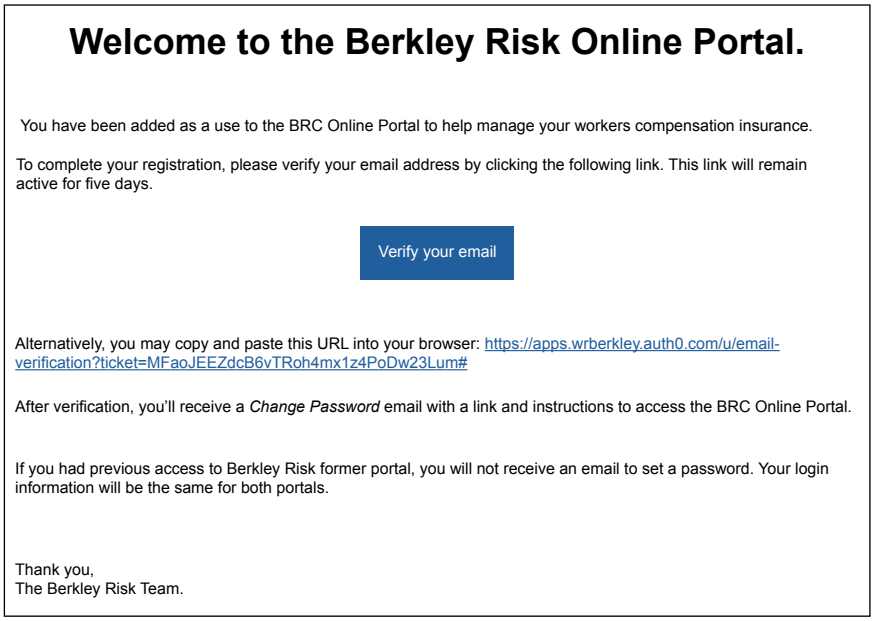
**Please distribute this claims kit to each of your locations and make sure that all key staff members know what to do when an employee gets injured at work.**

**Please report all claims within 24 hours of your knowing about them. Prompt claims reporting will allow Berkley Risk to start managing the claim and claims process immediately which can greatly impact the total cost of a claim.**

**For claims reporting you will always need your policy number, date of injury, location, employee's name, Social Security Number, home address, and if the employee has or will miss any work.**

# How To Create an Account:

1. You will receive two emails from: **BerkleyIdentitySupport@mail4.wrberkley.com**
   ** Please check your SPAM folder **
2. The first will have the subject line: **Verify your email**
3. Click the blue "Verify your email" box



**Welcome to the Berkley Risk Online Portal.**

You have been added as a use to the BRC Online Portal to help manage your workers compensation insurance.

To complete your registration, please verify your email address by clicking the following link. This link will remain active for five days.

Verify your email

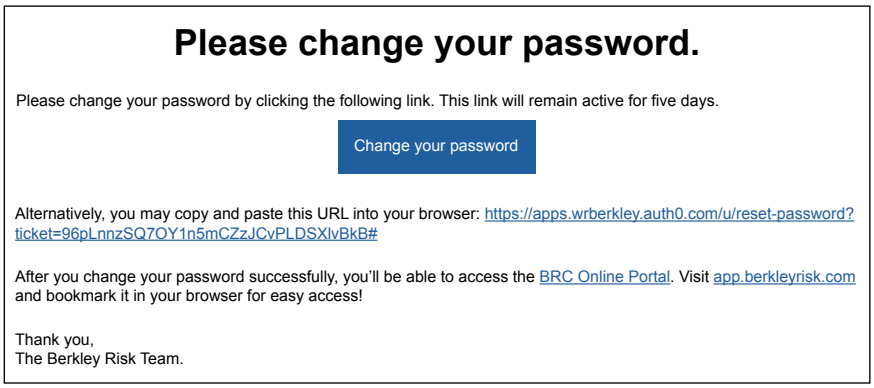
Alternatively, you may copy and paste this URL into your browser: https://apps.wrberkley.auth0.com/u/email-verification?ticket=MFaoJEEZdcB6vTRoh4mx1z4PoDw23Lum#

After verification, you'll receive a *Change Password* email with a link and instructions to access the BRC Online Portal.

If you had previous access to Berkley Risk former portal, you will not receive an email to set a password. Your login information will be the same for both portals.

Thank you,
The Berkley Risk Team.

4. The second email will have the subject line: **Reset your password**
5. Click the blue "Change your password" box



**Please change your password.**

Please change your password by clicking the following link. This link will remain active for five days.

Change your password

Alternatively, you may copy and paste this URL into your browser: https://apps.wrberkley.auth0.com/u/reset-password?ticket=96pLnnzSQ7OY1n5mCZzJCvPLDSXlvBkB#

After you change your password successfully, you'll be able to access the BRC Online Portal. Visit app.berkleyrisk.com and bookmark it in your browser for easy access!

Thank you,
The Berkley Risk Team.

6. Once you've set your password you can log in to **app.berkleyrisk.com** to get your policy documents, pay, report claims, and much more.

# How To Make a Payment Online:

1. Log in to your online portal account at [app.berkleyrisk.com](app.berkleyrisk.com).
2. Search/Select the Policy.
3. From the Policy Dashboard, click Make a Payment found under the "Billing" header.
4. Select the amount you would like to pay from one of three options:
    a) Amount Due: The total amount due to bring the policy up to date.
    b) Remaining Installments: The estimated premium to pay the policy in full.
    c) Custom Amount: A custom amount.
    This amount cannot be less than the minimum amount currently due.
5. Click "Select Payment Method" at the bottom of the screen.
6. When the pop-up appears on your screen, confirm the amount and select your Payment Method. Click Review to move on.
7. Confirm the payment information and click Pay to initiate the transaction.
8. A confirmation screen will appear once the transaction has been processed. You will have two options to save the transaction reference; you can Download Receipt or have a copy sent via email.
9. Once you are done, click Close to be redirected to the Billing Summary page.

**How To Add a New Payment Method:**

1. Click Manage next to the "Payment Method" header.
2. Select Add New Payment Method.
3. Complete all requested Account Information.
4. Confirm or change "Name on Account".
5. Select whether or not to make this your Default Payment Method.
6. Click Submit.

**How To Set Up Recurring Payments:**

1. On the Billing tab, select EDIT under Auto Pay.
2. Confirm your Default Payment Method and payments will be drafted automatically.

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# How to report your claim

**Please complete the enclosed**
Employee Injury Report to Employer Form and email along with all supporting documentation to:

Email: reportclaim@berkleyrisk.com

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**Claims – General Inquiries**
For all non-claim reporting inquiries, please contact:

claims@berkleyrisk.com

**Medical Bills & Medical Reports**
Please mail all medical bills and accompanying medical reports to our scanning center:

Gallagher Bassett Services, Inc.
PO Box 2831
Clinton, IA 52733-2831

**Medical Provider Lookup**
Use our Medical Provider Lookup tool to find the right doctor or provider near you:

www-sf.talispoint.com/gb/gbcare1/

All other correspondence can be sent directly to the handling adjuster.

**Electronic Billing**
For interested providers in states that require Electronic Billing - Please contact the Jopari eBilling Provider Intake Center:

1-866-269-0554

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# Employer Injury Reporting Checklist

## Step 1 –

### Accident Report

Employer (supervisor) completes the EMPLOYEE'S INJURY REPORT TO EMPLOYER with the injured Employee.

Employee's supervisor (or safety manager) investigates the incident to verify how it occurred.

Employer has any witnesses to the incident complete the WITNESS REPORT.

### First Report of Injury (FROI)

Employer (HR/WC Manager) completes the FROI (online at app.berkleyrisk.com preferred method) within 24 hours of notification of the injury.

## Step 2 –

### Physicians Report

After every doctor's appointment, the injured worker is to return to the employer either PHYSICIAN'S REPORT/EMPLOYEE WORK STATUS report or a form the physician's office has generated. Fax or email this form to Berkley Risk and/or your claims adjuster.

## Step 3 –

### Return To Work/Light Duty

Employer reviews the employee's restrictions indicated on the PHYSICIAN'S REPORT/ EMPLOYEE WORK STATUS. If employer is unable to provide modified work or accommodate light duty restrictions contact your claims adjuster immediately.

## Step 4 –

### Documentation

Employer should make copies of all forms for their records.

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Policy#

# Employee Injury Report to Employer Form

NOTE: This is NOT the First Report of Injury!

INSTRUCTIONS: (1) Employee's Injury Report. Employee must notify their employer of any work-related injuries immediately. The injured employee and their supervisor completes Part 1 of this form. The supervisor (or safety representative) conducts investigation and completes Part 2 of this form. The form is provided to employer's workers' compensation manager (WCM). (2) First Report of Injury. The WCM completes the First Report of Injury.

(FROI) based on Employee's Injury Report (EIR) and any verbal clarification made by the injured employee. (3) Notifying BERKLEY RISK. WCM submits FROI and EIR to BERKLEY RISK.

Company Name: _____

Last: _____ First Name: _____ Middle Initial:_____

Date of Birth: _____ Social Security Number:_____

Home Address: _____

City: _____ State: _____ Zip Code: _____ Phone: (  )_____

Date of Injury: _____ Date Reported: _____ Time of Injury: _____ a.m. _____ p.m.

Date-Time Left Work: _____ Date-Time Returned: _____ Lost Time: ☐ Yes ☐ No

Where on the Body is the Injury: _____

Employee's Explanation for Injury: _____

Name(s) of Witness(es) to Injury: _____

Name of Person Completing This Form/Conducting Investigation: _____

**Cause:**

- ☐ Burn, Scald, Exposure, Contact Injury
- ☐ Caught In, Under, or Between
- ☐ Cut, Puncture, Scrape, Injured By
- ☐ Fall, Slip or Trip
- ☐ Motor Vehicle
- ☐ Repetitive Motion Injury
- ☐ Rubbed or Abraded By
- ☐ Strain or Injured By
- ☐ Striking Against or Stepping On
- ☐ Struck or Injured By (kick, stabbed, bit)

**Type of Injury:**

- ☐ No Apparent Injury
- ☐ Amputation
- ☐ Burn
- ☐ Contusion
- ☐ Crushing
- ☐ Electrical Shock
- ☐ Cumulative Trauma (repetitive motion)
- ☐ Foreign Body (e.g., in eye, etc.)
- ☐ Laceration/Cut
- ☐ Puncture (e.g. needlestick)
- ☐ Sprain/Strain
- ☐ Other: _____

**Was There a:**

- ☐ Safety Rule Violation (explain): _____
- ☐ Other Violation (explain): _____
- ☐ Machine Malfunction (explain):_____
- ☐ Motor Vehicle Accident

**Employee Referred to:**

- ☐ Designated Medical Provider — Specify: _____
- ☐ Hospital Emergency Room — Specify: _____
- ☐ Declines Medical Care At This Time

What Actions are Being Taken to Prevent a Recurrence: _____

Date-Time Supervisor Notified: _____ Date-Time Accident Report Completed: _____

Findings/Comments:

Supervisor's Signature: _____ Date: _____

Employee's Signature: _____ Date: _____

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# Witness Reporting Form

Injured Employee: _____

Date of Injury: _____

Time of Injury: _____

Witness Name: _____

Witness Address: _____

Witness Phone: _____

What is your relationship to the injured person? _____

Did you actually witness the incident? ☐ Yes ☐ No

If no, what time did you arrive at the scene? _____

What did you see when you arrived? _____

If you witnessed the incident, please describe what you saw happen:

In your opinion, what was the cause of the incident?

Do you know of any other people who may have witnessed this incident?
If so, please state their names and contact information.

Witness Signature: _____ Date: _____

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# Physician Report/Employee Work Status

## Send With Injured Employee to Appointment

Physician: Please ensure that the employee receives a copy of this form and/or that it is faxed to employer.

Employee Name: _____

Employer Name: _____ Fax:_____

Insurance Company: Berkley Risk (and its Subsidiary Insurance Companies).
Phone: 612-766-3000 Fax: 612-766-3099
Dx: _____

Work Related: ☐ Not Work Related: ☐ Undetermined: ☐
RX:_____

☐ Physical Therapy at:_____ Frequency _____ Duration_____

☐ Return to Work Regular Duty: ____/____/____ (Date) MMI: Yes ☐ No ☐ ____/____/____ (Date) PPD _____%

☐ Return to Restricted Work: ____/____/____ (Date) To: ____/____/____ (Date)

| **Employee Can:** | | **Never** | **Occasional** | **Frequent** | **Continuous** |
|---|---|---|---|---|---|
| **Lift/Carry** | 0 to 10# | ☐ | ☐ | ☐ | ☐ |
| | 11 to 25# | ☐ | ☐ | ☐ | ☐ |
| | 26 to 35# | ☐ | ☐ | ☐ | ☐ |
| | 36 to 50# | ☐ | ☐ | ☐ | ☐ |
| | 51 to 75# | ☐ | ☐ | ☐ | ☐ |
| | 76 to 100# | ☐ | ☐ | ☐ | ☐ |
| | Reach Above Shoulder | ☐ | ☐ | ☐ | ☐ |
| | Push/Pull | ☐ | ☐ | ☐ | ☐ |
| | Squat/Kneel/Stoop | ☐ | ☐ | ☐ | ☐ |
| | Bending | ☐ | ☐ | ☐ | ☐ |
| **Can Use L/R Hand For:** | Simple Grasping | ☐ | ☐ | ☐ | ☐ |
| | Firm Grasping | ☐ | ☐ | ☐ | ☐ |
| | Fine Manipulation | ☐ | ☐ | ☐ | ☐ |
| | Torquing | ☐ | ☐ | ☐ | ☐ |

Work Hours: ____ Full Shift ____ Partial Shift or _____ /_____ Hrs/Day (restricted)

No. of Hours/Day _____ /_____ Sitting _____ /_____ Standing _____ /_____ Walking

Modifications Apply to: ____ Work ____ Home ____ Leisure

**This patient's employer has a "return-to-work program" and is committed to providing work within any restrictions.**

Unable to Work From: ____/____/____ (Date) To: ____/____/____ (Date)

Additional Comments: _____

Return to Clinic on: ____/____/____ (Date)

Referral to: _____

Physician's Signature: _____ Date: ____/____/____

Printed Name: _____ Clinic: _____

Address: _____ City: _____

Phone: _____ Fax: _____

Optum
PO Box 152539
Tampa, FL 33684-2539

# MAKING IT EASY...
## TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

### Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-764-4795 or visit tmesys.com.

**Questions? Need Help?**

**1-866-764-4795**

OPTUM® GALLAGHER BASSETT

**WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM**

Gallager Bassett Services, 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:** Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

**Tmesys Pharmacy Help Desk**
**1-866-764-4795**

| | NDC | | Envoy |
|---|---|---|---|
| RxBIN | 004261 | or | 002538 |
| RxPCN | CAL | or | Envoy Acct. # |
| GROUP | J115 | | |

***NOTE:*** *This First Fill card is only valid for your workers' compensation injury or illness.*

### Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.



tmesys®

IMP14-1614-150-GBFF