



EMERGENCY TREATMENT: ESSENTIAL INFORMATION FOR EMPLOYERS

Please complete during initial emergency treatment and submit to Synergy with First Report of Injury.

Employee Name: _____ Date of Accident: _____

Employee Date of Birth (if available): _____ Employee SSN (if available): _____

Place of Accident: _____

Employee transported by: Ambulance Private vehicle

If Ambulance, name of EMS service: _____

Did EMS administer pain medication? Yes No Unknown

Name of employee who accompanied injured worker to Emergency Room: _____

Phone number: _____

Hospital providing emergency services: _____

Was employee seen at another facility prior to the ER (i.e., Urgent Care, local hospital)? Yes No

If yes, name of facility: _____

Please complete the following activities:

- Inform Charge Nurse that this is a workers' compensation injury and inquire if a drug test can be performed.
 - If drug test was not performed, notify Synergy ASAP by calling 1-866-987-0042**
- If able, have employee sign drug test release and give to Charge Nurse.
- Communicate with employee's emergency/family contact.

Name: _____ Phone: _____

- Ask for details of care & expected length of hospital stay.

Notes:

- Report claim to Synergy at www.synergyinsurance.net/report-a-claim or by calling 1-877-327-5444.

REMINDER: If drug test was not performed, notify Synergy ASAP by calling 1-866-987-0042



WORKERS' COMPENSATION INJURED WORKER

Medical & Drug Test Authorization

The undersigned person hereby consents to, and by the Authorization or any photocopy hereof authorizes the collection of and release to Synergy Coverage Solutions, their designated laboratory, Medical Review Officer or any other agent or employee of Synergy Coverage Solutions by any hospital, medical clinic, physician, or any other provider of medical services, treatment, or supplies of any and all laboratory specimens, i.e. blood and/or urine, collected on _____ for the purpose of drug and/or alcohol testing by an independent laboratory. (Date of injury)

The undersigned understands and hereby acknowledges that the information above or certain portions there of, may be protected from disclosure without this signed Authorization by Federal and State privacy and confidentiality laws. Further, the undersigned person understands and acknowledges that the refusal to sign this Authorization could affect their workers' compensation claim and/or employment based on state statutes, laws and/or any employment agreement in effect.

This Authorization shall automatically expire without express revocation on the 31st day after the signature date of this authorization; and prior to such time shall be subject to revocation with respect to all or any particular records at any time by the undersigned person in writing delivered to the holder of such records except to the extent that action has already been taken in reliance upon this Authorization.

Date: _____ Injured Employee: _____
(Print Name)
Injured Employee: _____
(Signed Name)
Witness: _____
(Print Name)
Witness: _____
(Signed Name)

The undersigned person DOES NOT consent to the above authorization and understands that the refusal of a drug and/or alcohol test could negatively affect his/her workers' compensation claim and/or employment.

Date: _____ Injured Employee: _____
(Print Name)
Injured Employee: _____
(Signed Name)
Witness: _____
(Print Name)
Witness: _____
(Signed Name)



SYNERGY
COVERAGE SOLUTIONS

Committed to superior service and innovative solutions.

BILLING INFORMATION FOR EMERGENCY TREATMENT

Employee Name: _____ Date of Accident: _____

Employee Date of Birth: _____ Employee SSN: _____

Employer Name: _____

Registration Staff,

This letter will verify that the above-mentioned employee has been injured on the job. All bills must be accompanied by medical notes and should be sent to the Workers' Compensation administrator:

**Synergy Coverage Solutions
217 South Tryon Street
Charlotte, NC 28202**

You may also securely upload files online at www.synergyinsurance.net/file-upload for faster processing.

*Please do not send any medical bills to the patient.

PLEASE NOTE: This is a workers' compensation injury and medical notes are REQUIRED to be included with all bills for payment. Bills without medical notes will be returned without payment and denied.

If you have any billing questions, please call Synergy Coverage Solutions at (704) 927-2860 or 1-866-710-0908.

MAIN (704) 927-2860 • FAX (704) 927-2867

www.synergyinsurance.net • info@synergyinsurance.net

Synergy Coverage Solutions, 217 South Tryon Street, Charlotte, NC 28202



WORKERS' COMPENSATION CLAIM - EMERGENCY ROOM VISIT TO DO LIST

IMMEDIATE ACTION

1. Transport the injured worker to the hospital by calling 911 or through another safe means of transportation.
2. Go with the injured worker or meet them at the hospital.
 - a. Inform Registration Staff that this is a workers' compensation injury and all bills & medical notes should be sent to Synergy Coverage Solutions:

Synergy Coverage Solutions		Securely upload medical notes & bills to:
217 South Tryon Street	or	www.synergyinsurance.net/file-upload
Charlotte, NC 28202		
P: (704) 927-2867		
F: (704) 927-2867		
 - b. If able, have the injured worker sign the Medical & Drug Test Authorization for the drug test and hand to the Charge Nurse.
 - c. Explain to the Charge Nurse that this is a workers' compensation claim and inquire if a drug test can be performed; charges will be honored and paid within 30 days.
3. Assist with phone calls to the injured worker's family that are necessary or requested.
4. Get as much information as possible on the injured worker's expected treatment and length of hospital stay. Document information on the Emergency Treatment: Essential Information for Employers form and submit to Synergy with First Report of Injury.

TO DO by end of injury day

1. **If the facility refuses to perform a drug test, contact Synergy as soon as possible, to discuss details of the drug testing request and any other pertinent medical information you may know.**
Call: **1-866-987-0042**
Have available:
 - Full name of injured worker with correct spelling
 - Date of birth
 - Social Security Number
 - Hospital location name (if treated at a different hospital initially, both locations are needed)**If you reach voicemail, please leave ALL of the above information on a recorded voicemail message.**
2. Report the claim to Synergy Coverage Solutions.
Online: www.synergyinsurance.net/report-a-claim
By Phone: 1-877-327-5444
3. Obtain pictures of the accident scene prior to its spoilage. Pictures from a mobile device are acceptable.