## CLAIM MANAGEMENT CHECK-LIST (Workers Compensation) (Please attach this document to the outside of internal claim folder)

Workers Name:	Date of Accider	nt: Store #:	
STORE MANAGER			
☐ Initiate choice of	medical provider set by your state	e (if applicable)	
☐ Send the injured	worker for a post-accident drug s	creen (if applicable	in your HR policy)
$\Box$ If the injured wor	ker declines care, have them sigr	the waiver of med	ical treatment form
Complete and pe	erform an Accident Investigation (	complete the form)	
🗌 Report Claim – ir	nmediately (always within 24 hou	rs)	
o Everythin	g sent to the Insurance Company	<sup>,</sup> (or your Main Offic	ce)
CLAIMS MANAGER			
<ul> <li>Contact c</li> </ul>	aved nd review video as soon as possil laims adjuster or main office to le east 30 minutes of video before a	t them know what c	
• Ri • Yo	with the worker to schedule their equest that the injured worker retron ou only have a DAY WAITING aportant to get the injured worker	urn to you with a wo PERIOD (waiting p	eriod varies by state). It is
<ul> <li>Contact y accident</li> </ul>	Leadership Communication) our leadership if it is not going to date or if they do not follow up wit claims adjuster with an update		rn them in DAYS from the
☐ Follow-up with S ○ Ensured	tore Manager worker returned by the specified t	ime/date	