# CSC Claim Response and Reporting Instructions to Sage and CTTPA

**For both Longshore and State claims if the injured worker needs medical care:**

1. Please provide the injured worker with the **New Injury Packet**. All of this packet should go with the injured worker **EXCEPT** the signed medical release to allow us to obtain the medical records. The packet should include:

    1. **Sage Adjuster contact sheet**—Please let them know a Sage adjuster will be contacting them immediately and at least within 24 hours. This sheet goes with the injured worker.
    2. **Medical facility options sheet with addresses and phone numbers – Dr Dan Nemeth or Roper Express Care**
    Please instruct the injured worker to go to Dr. Dan Nemeth in Mt. Pleasant if it is during normal business hours (8am-5pm). If the injury occurs after 5pm on a weekday or on the weekend, then please direct them to the Roper Express Care location on University Blvd (full addresses on sheet). If the injured worker requires medical treatment after 8pm or before 8am, please send them to the nearest hospital for emergency room treatment. This sheet goes with the injured worker.
    3. **Medical release form**—Please have the injured worker or supervisor complete the top of the form and the injured worker sign it—**This signed form should be sent with the incident report to Amy Mathisen.**
    4. **MyMatrix Pharmacy card**—This sheet allows for a first fill prescription before his/her prescription card arrives in the mail—This sheet goes with injured worker

2. Complete the internal accident investigation report for Charleston Stevedoring Company with all the requested information. It must be printed legibly and **must** include the injured workers' date of birth, SSN, address, phone number, and terminal location of accident to allow Sage to open a new claim.

3. Complete CSC post-accident internal investigation and post-accident drug/alcohol screens. Please have all parties involved in the accident drug/alcohol tested regardless of whether medical treatment is requested or not. Positive drug/alcohol screen should be communicated to Sage Adjusting immediately.

4. Email Amy Mathisen at amy.mathisen@sageusa.com about the new claim with the CSC internal incident report and signed medical release form (signed by the injured worker) as attachments to the email

-For an emergency or situation needing immediate attention (severe injury, amputation, possible internal injuries, loss of consciousness, or death), please immediately call Amy Mathisen at (843) 906-7905 or Robbie Harrison at (843) 270-4976.

-Please direct any questions concerning claim reporting to:

**Account manager**

**Amy E. Mathisen**
Senior Vice President
Mt Pleasant, SC office
T: +1 843 258 3521
F: +1 843 258 3521
M: +1 843 906 7905
amy.mathisen@sageusa.com

# PLEASE SEND THIS FORM WITH THE INJURED WORKER

**FOR MEDICAL TREATMENT, PLEASE GO TO THE FOLLOWING FACILITIES WHERE BILLING HAS BEEN PRE-ARRANGED. DR. NEMETH'S OFFICE PREFERS AN ADVANCE CALL. WALK-INS ARE WELCOME AT ROPER EXPRESS.**

**For Monday-Friday (see office hours below):**

Dr. Dan Nemeth
929 Bowman Road, Suite 400
Mt. Pleasant, SC 29464
(843) 733-3444

**OFFICE HOURS:**

Monday 8:00 AM – 5:00 PM
Tuesday 8:00 AM – 2:00 PM
Wednesday 8:00 AM – 5:00 PM
Thursday 8:00 AM – 5:00 PM
Friday 8:00 AM – 2:00 PM

**For after normal business hours and on weekends (8am-8pm):**

**Roper Express Care**
8901 University Blvd.
North Charleston, SC 29406
(843) 203-2245

**For after Roper Express Care hours, please proceed to the nearest hospital.**

**PLEASE HAVE THE INJURED WORKER COMPLETE THE HIGHLIGHTED PORTION AND SIGN BELOW**

# AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

## *PATIENT INFORMATION*

(Please Print)

Patient Name:_____ Street Address:_____

City:_____ State: _____ Date of Birth:_____

I hereby authorize:_____

## *REQUEST/RECIPIENT INFORMATION*

Please disclose the following protected health information to: Sage Adjusting LLC.

Street Address: 100 Century Parkway, Ste. 300

City: Mount Laurel State: NJ Zip Code: 08054

Please indicate the information or types of information to be disclosed: Any and all records

**Specify dates** (or date ranges) if applicable:_____

This request is for the purpose of: Insurance Claim

I understand that I have the right to revoke this authorization at anytime. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics.

**THIS INFORMATION WILL ALSO BE RELEASED UNLESS YOU INITIAL HERE; DO NOT RELEASE:_____.**

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Description of Representative's Authority (witness signature required) Signature of Witness

PLEASE SEND THIS FORM WITH THE INJURED WORKER

myMatrixx®
good medicine for business

# Signal Mutual Indemnity Association, LTD.
# Workers' Compensation Prescription Information

## Employer:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

| | |
|---|---|
| Employee Name: | |
| Group#: | 10602823 |
| Employee ID (SSN): | |
| Date of Injury: | |
| Processor: | myMatrixx |
| Bin#: | 014211 |
| Day supply is limited to 30 days for a new injury. | |
| myMatrixx Help Desk: (877) 804-4900 | |

## Employee:

Signal Mutual Indemnity Association LTD. has partnered with ***myMatrixx*** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 64,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

**IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900**

---

## Pharmacist:

Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

**FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900**

---

CADENCE Rx
PEER TO PEER PRESCRIPTION PLATFORM

SIGNAL Sage

# Información sobre recetas médicas de compensación para trabajadores

**Empleador:**
Complete la información del empleado a continuación y proporcione al empleado este documento para que lo lleve a cualquier farmacia para sus recetas de compensación para trabajadores.

---

**Empleado:**
**Signal Mutual** se ha asociado con Cadence Rx para facilitar el surtido de recetas de compensación para trabajadores.

Este documento sirve como tarjeta de prescripción temporal. Se le enviará directamente una tarjeta de prescripción permanente específica para su lesión dentro de los próximos 3 a 5 días hábiles.

Lleve esta carta y su(s) receta(s) a una farmacia cercana. Cadence Rx tiene una red de más de 72,000 farmacias en todo el país. Para ubicar una farmacia de la red cerca de usted, use el localizador de farmacias en http://cadencerx.com/find-a-pharmacy/ o llame gratis a Cadence Rx al 1-888-813-0023.

**SI TIENE ALGUNA PREGUNTA O NECESITA AYUDA EN LA FARMACIA, LLAME AL 1-888-813-0023**

---

**Farmacéutico:**
Obtenga la siguiente información del empleado lesionado si aún no la ha completado el empleador para procesar las recetas solo para la lesión de compensación del trabajador.

Si tiene preguntas o rechaza, llame al 1-888-813-0023. Por favor no envíe al paciente a casa ni haga que el paciente pague por los medicamentos antes de llamar a Cadence Rx para solicitar ayuda.

**NOTA:** Ciertos medicamentos están preprobados para este paciente; estos medicamentos se procesarán sin una autorización. Todos los demás requerirán aprobación previa.

**PARA CUALQUIER PREGUNTA O AYUDA CON APROBACIONES DE MEDICAMENTOS, LLAME AL: 1-888-813-0023**

## Tarjeta de identificación de medicamentos recetados

CADENCE Rx
PEER TO PEER PRESCRIPTION PLATFORM

SIGNAL Sage

| | |
|---|---|
| **Nombre del Empledo:** | |
| **No de ID de Miembro** | **FF*** |
| **Fecha de la lesión:** | |
| **Nombre del Grupo:** | **CHARLESTAYLOR** |
| **Número PCN:** | **CRX** |
| **Número BIN:** | **021460** |

**Tarjeta creada el: ____/____/____**
**Tarjeta válida solo para la fecha de la lesión**

## Información de farmacia

Este formulario le permite surtir sus recetas iniciales con un costo máximo de $150 por medicamento y un suministro de no más de 30 días por receta. Farmacia, si necesita ayuda para procesar este reclamo, llame al 1-888-813-0023.

La tarjeta de beneficios de farmacia solo debe usarse para medicamentos recetados para su lesión relacionada con el trabajo. Al usar esta tarjeta, usted reconoce y acepta la responsabilidad financiera por cualquier receta facturada con esta tarjeta que luego se descubra que no está relacionada con su lesión.

- **Formato de identificación de miembro: la identificación debe comenzar con FF seguido de los últimos 4 dígitos del número de seguro social más la fecha de la lesión de 8 dígitos (MMDDYYYY). Ejemplo: FF999901302018**

CADENCE Rx
PEER TO PEER PRESCRIPTION PLATFORM

SIGNAL Sage

# Workers' Compensation Prescription Information

**Employer:**
Please fill out employee information below and provide employee with this document to take to any pharmacy for his/her Workers' Compensation prescriptions.

---

**Employee:**
**Signal Mutual** has partnered with Cadence Rx to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. Cadence Rx has a network of over 72,000 pharmacies nationwide. To locate a network pharmacy near you, please use the pharmacy locator at http://cadencerx.com/find-a-pharmacy/ or call Cadence Rx toll free at 1-888-813-0023.

**IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE AT THE PHARMACY PLEASE CALL**
**1-888-813-0023**

---

**Pharmacist:**
Please obtain below information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only.

For questions or rejections please call 1-888-813-0023. Please do not send patient home or have patient pay for medication(s) before calling Cadence Rx for assistance.

**NOTE:** Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

**FOR ANY QUESTIONS OR ASSISTANCE WITH MEDICATION APPROVALS PLEASE CALL:**
**1-888-813-0023**

## Prescription Drug ID Card

CADENCE Rx
PEER TO PEER PRESCRIPTION PLATFORM

SIGNAL Sage

| | |
|---|---|
| **Employee Name:** | |
| **Member ID Number*** | **FF*** |
| **Date of Injury:** | |
| **Group Number:** | **CHARLESTAYLOR** |
| **PCN Number:** | **CRX** |
| **BIN Number:** | **021460** |

**Card Created On: ____/____/____**
**Card Valid for Date of Injury Only**

## Pharmacy Information

This form allows you to fill your initial prescriptions with a maximum cost of $150 per medication and no more than a 30-day supply per prescription. Pharmacy, if you need assistance processing this claim, please call 1-888-813-0023.

The pharmacy benefit card is only to be used for medications prescribed for your work-related injury. By using this card, you acknowledge and accept financial responsibility for any prescriptions billed under this card that are later found to be unrelated to your injury.

- **Member ID format: The ID must start with FF followed by the last 4 digits of social security number plus 8- digit Date of Injury (MMDDYYYY). Example: FF999901302018**

# Sage Adjusting Contact List

## Account manager

**Amy E. Mathisen**
Senior Vice President
Mt Pleasant, SC office
T: +1 843 258 3521
F: +1 843 258 3521
amy.mathisen@sageusa.com

## Senior Indemnity Adjuster

**Terri L. Schaffer**
Vice President
Wilton, CT office
T: +1 203 405 5946
F: +1 203 405 5946
terri.schaffer@sageusa.com

## Senior Indemnity Adjuster

**Amy Phelps**
Vice President
Mobile, AL office
T: +1 251 230 2172
F: +1 251 230 2172
amy.phelps@sageusa.com

## Senior Indemnity-Medical Only Adjuster

**Robbie B. Harrison**
Senior Claims Adjuster
Charleston, SC Office
T: +1 843-258-3520
F: +1 843-258-3520
robbie.harrison@sageusa.com

## State Adjuster (CTTPA)

**Mollie Harrison**
Claims Adjuster
825 Lowcountry Blvd, Suite 101
Mt. Pleasant, SC 29464
T: +203-210-0237
F: +203-210-1699
Mollie.Harrison@ctplc.com