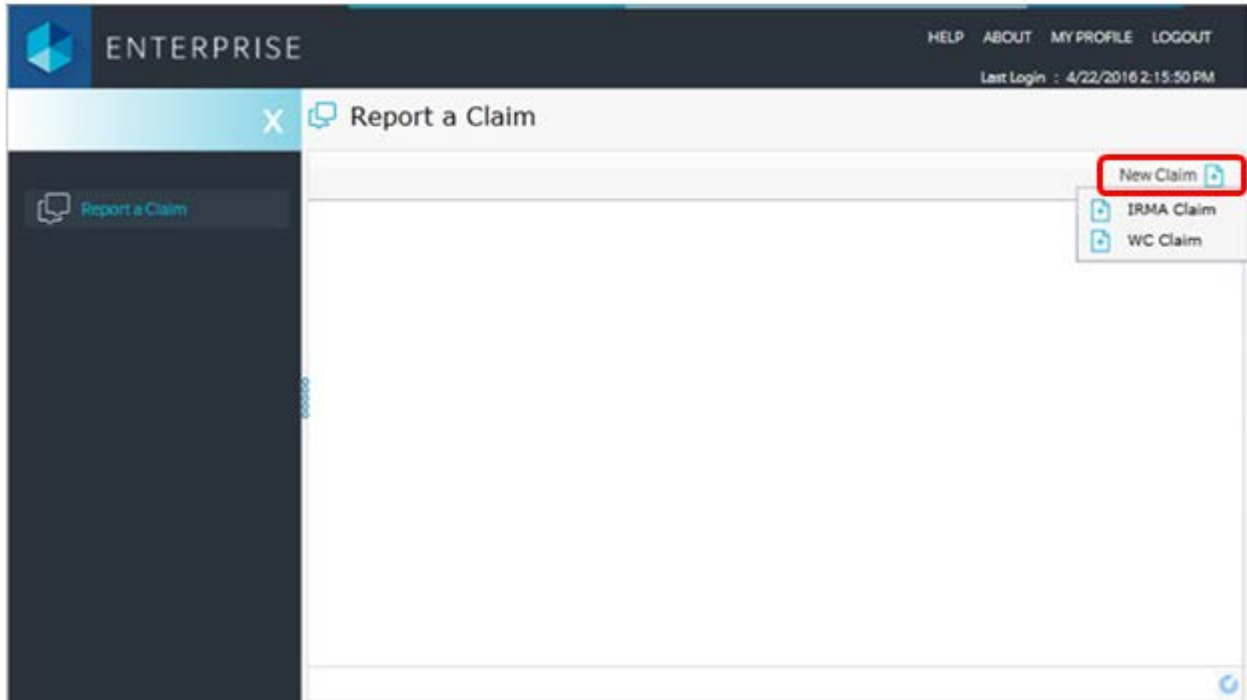


Member Claim Reporting

1. Click on the link through the ACCG portal to report a claim
2. Click on the New Claim icon, and choose which program you are reporting into. Below is an example for WC.



3. Complete the fields on the screen. If a field is marked with a red asterisk *, it is required and must be completed

* Date of injury	<M/dV/yyyy> 15 (mm/dd/yyyy)
* Please select County/Member	<input type="text"/>
Employee Information	
* Employee first name	<input type="text"/>
* Employee last name	<input type="text"/>
* Employee social security number	<input type="text"/> (no dashes)
* Occupation	<input type="text"/>
* Employee address	<input type="text"/>
* Employee city	<input type="text"/>
* Employee state	Georgia <input type="text"/>
* Employee zip code	<input type="text"/>
* Date of birth	<M/dV/yyyy> 15 (mm/dd/yyyy)
Employee home phone	<input type="text"/> - <input type="text"/> - <input type="text"/> (xxx-xxx-xxxx)

4. The Location field must be completed with your Member number. The drop down provided will list what your Member number is.

* Date of injury 15 (mm/dd/yyyy)

* Please select County/Member

Employee Information

* Employee first name

* Employee last name

* Employee social security number (no dashes)

* Occupation

* Employee address

* Employee city

* Employee state

* Employee zip code

* Date of birth 15 (mm/dd/yyyy)

Employee home phone - - (xxx-xxx-xxxx)

Employee cell phone - - (xxx-xxx-xxxx)

Description	Code
ACCG	0050

5. Once all fields have been completed, you will find a submit option at the bottom of the screen.

Treating physician

Treating hospital/facility

Facility address 1

Facility address 2

Facility city

Facility state

Facility zip code

Facility / physician phone number - - (xxx-xxx-xxxx)

* Initial treatment

Report Information

* Your name

* Position

* Telephone number - - (xxx-xxx-xxxx)

* Your email address

* Indicates a required field

Treating hospital/facility

Facility address 1

Facility address 2

Facility city

Facility state

Facility zip code

Facility / physician phone number

Initial treatment

Minor On-Site Remedies by Employer

Are you sure you want to submit?

Are you sure you want to submit?

Yes No

Report Information

Your name: Freddie

Position: Gonzalez

Telephone number: 404 - 555 - 2912

Your email address: freddie@braves.com

Submit Cancel Close Page

6. Upon completion, a summary page will appear to recap what was entered.

Thank you for using the ACCG claim reporting system. 4/22/2016

Your claim has been received by the ACCG Claims Department. Below is a brief summary:

Employee	Freeman, Freddie
Claim number	7250093023
Occupation	Parks & Recreation
Date of injury	4/22/2016
Time of injury	
Place of accident/exposure	
County	Appling County
Type of injury/illness	Dislocation
Part of body affected	Shoulder(s)
How injury/illness occurred	Playing Baseball
Initial treatment	Minor On-Site Remedies by Employer
Report prepared by	Freddie

A written acknowledgement will be mailed within two business days to provide the name and direct phone number of the examiner assigned to the claim. If you do not receive a copy of the acknowledgement letter, please call the claims department at 1-877-421-6298.

7. A confirmation will be emailed to the user submitting the incident.

<p>Subject: A New WC Claim has been entered through the Internet</p> <p>A new WC claim has been entered for 0200</p> <p>Claim Number: 7250093021 Claimant: Mann, Oliver Accident Date: 4/5/2016 Report Date: 4/19/2016 Date of Birth: 6/6/1989</p>	<p>Subject: A new IRMA Claim has been reported through the Internet</p> <p>A new IRMA claim has been entered for 0200</p> <p>Claim Number: 6250049024 Claimant: Atkinson County Accident Date: 4/5/2016 Report Date: 4/19/2016</p>
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8. An acknowledgement letter will be emailed to the County Contact on file with ACCG when i.

From: ACCG_Notification_Donotreply@accg.org
To: Fusco, Tim
Cc:
Subject: FW: New Claim Notification 7250093023 - Freeman, Freddie

Employer: ACCG
Department: Parks & Recreation
Injury Date: 4/22/2016
Claim #: 7250093023

Dear Freddie Freeman:

This letter will serve to acknowledge receipt of the First Report of Injury submitted on your behalf by your employer on 4/22/2016.

The following team has been assigned to assist in the investigation and resolution of your claim. Please call us if you have any questions or concerns.

Contact Information Not defined	Contact this person for: Questions about claim compensability Questions about benefit payment
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Not defined or call toll-free 1-877-421-6298

Following an injury or illness arising out of and in the course of employment, your employer is required to pay all reasonable, necessary and authorized medical expenses. Authorized prescriptions and medical treatment paid by you are reimbursable. You will be receiving a workers' compensation prescription card directly from Express Scripts. To locate a participating pharmacy, call 1-800-945-5951 or visit www.accg.org. Look for the Workers' Compensation Pharmacy Locator under the "ACCG Insurance ProgramsTab."

Mileage for authorized medical treatment is reimbursable at 40 cents per mile. A mileage reimbursement form is attached for your convenience.

For all inquiries regarding payment of medical bills, please call 678-225-4258.

Sincerely,