

Georgia Education Workers'
Compensation Trust



Georgia Education Worker's Compensation Trust

ON-LINE CLAIMS REPORTING MANUAL

June 2018



1775 SPECTRUM DRIVE

SUITE 100

LAWRENCEVILLE, GEORGIA 30043

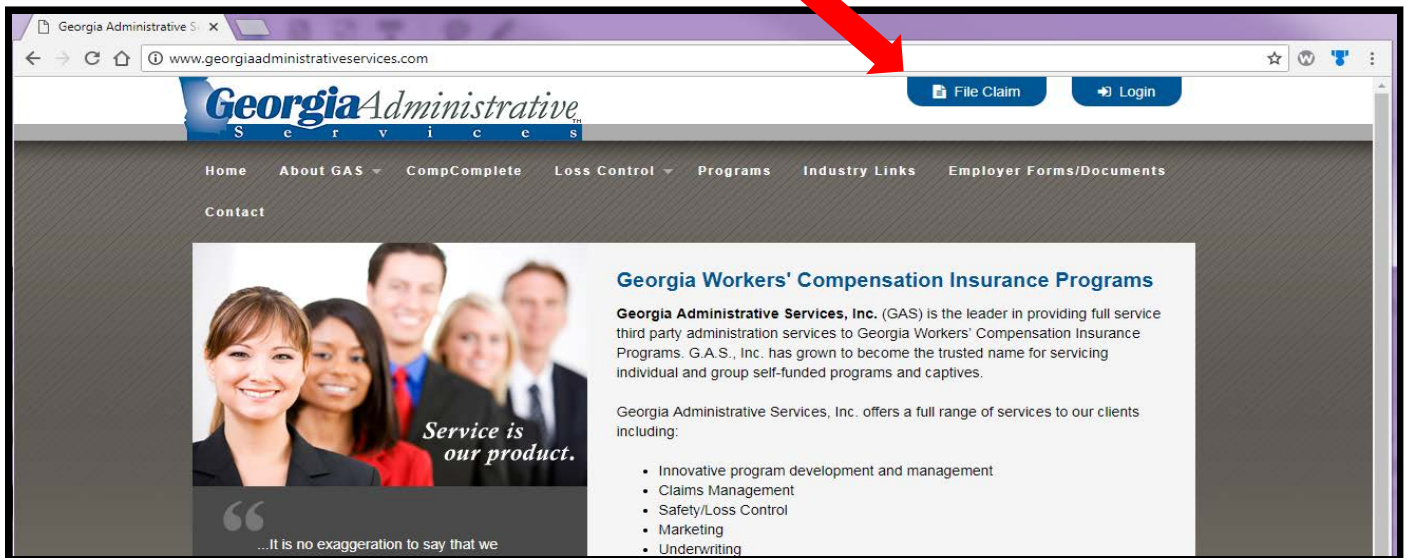
770-963-7732/1-800-421-0710

WWW.GEORGIAADMINISTRATIVESERVICES.COM

Welcome to the Georgia Administrative Services User's Guide for online submission of an Employer's First Report of Injury (WC1). Here we will cover how to navigate and successfully create a new claim for your employee.

Step 1: Navigating to the system

- Type <http://www.georgiaadministrativeservices.com/> into your web browser to go to the G.A.S home page. (You may wish to bookmark this page.)
- Click on **"File Claim"** in the top right of the screen.



- Clicking **"File Claim"** will take you to this page.

- You should see 5 Tabs:

1. **Employer**
2. **Claimant**
3. **Employment**
4. **Injury**
5. **Submitter**

- These 5 tabs break the WC-1 into smaller sections of related information making it easier to complete.
- To navigate tabs, you can use the Next and Previous buttons or select the appropriate tab at the top of the page.

A screenshot of the 'File Claim' form page. The 'Employer' tab is selected. The form contains the following fields: Insurance ID # (text input), Employer Name (text input with a dropdown arrow), Nature of Business (text input), Address (text input), Address 2 (text input), City (text input), State (dropdown menu), Zip (text input), Employee Supervisor's Name (text input), Employee Supervisor's Phone Number (text input with a dropdown arrow), and Employee Supervisor's Email (text input). A 'Next' button is located at the bottom of the form. On the left side, there is a 'Site Options' menu with 'File Claim (WC1)' selected, 'File Wage Statement (WC6)', and 'Login'.

Step 2: Filing the Claim

Note: Any area marked with an asterisk (*) is a required field and the WC-1 cannot be submitted without this information.

EMPLOYER TAB

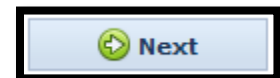


This tab contains the information necessary for G.A.S. to identify the correct employer/insurer.

- **Insurance ID #:** Enter your “Insurance Company” code and tab to the next box. (For Georgia Education Worker’s Compensation Trust enter 30017).
- **Employer Name:** Use drop down to find school system/insured name.
- **Location Name:** Leave this as (None).
- **Nature of Business:** This will default to “SCHOOL SYSTEM”.
- **Address Information:** This will default to the address on file for the Employer.
- **Employee Supervisor’s Name:** Please enter the Supervisor’s Name for the injured Employee.
- **Employee Supervisor’s Phone Number:** Please enter the Supervisor’s Phone for the injured Employee.
- **Employee Supervisor’s Email:** Please enter the Supervisor’s Email for the injured Employee.

****Note: Employee Supervisor’s Name, Phone Number and Email Address are critical for future communication.****

Once you have completed the required fields, click “Next”.



CLAIMANT TAB



This provides the employee’s demographic information for the WC1. This information may be submitted to the State Board of Workers’ Compensation, attorneys and medical providers. Accuracy is extremely important.

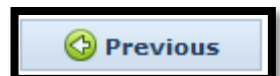
- **Employee First Name:** Enter the Claimant’s First Name.
- **Employee Last Name:** Enter the Claimant’s Last Name.
- **Employee Middle Initial:** If known, enter the Claimant’s Middle Initial.
- **SSN:** Enter the Claimant’s Social Security Number.
- **Address Information:** Enter the Claimant’s Address, City, State, and Zip Code.
- **Gender:** Please enter the Gender of the Claimant.
- **Birthdate:** Please enter the Date the Claimant was born.
- **Phone Number:** Please provide a phone number so we can contact the Claimant.
- **Email:** If known, please enter the Claimant’s Email.

A screenshot of the 'File Claim' web application. The 'Claimant' tab is selected. The form contains the following fields: 'Employee First Name:*' (text input), 'Employee Last Name:*' (text input), 'Middle Initial:' (text input), 'SSN:*' (text input with dashes), 'Address:*' (text input), 'Address 2:' (text input), 'City:*' (text input), 'State:*' (dropdown menu), 'Zip:*' (text input), 'Gender:*' (radio buttons for Male and Female), 'Birthdate:*' (dropdown menu), 'Phone Number:' (text input with area code), and 'Email:' (text input). At the bottom are 'Previous' and 'Next' buttons.

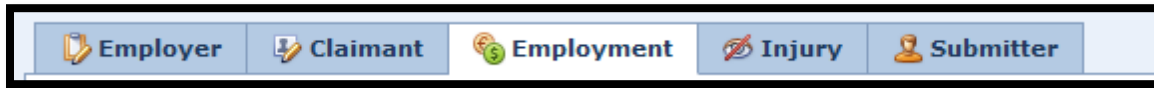
Once you have completed the required fields, click “Next”.



If you would like to go back to the prior tab, click “Previous” or click on the tab at the top of the page.



EMPLOYMENT TAB



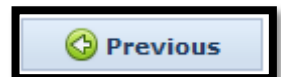
Required fields are marked with an asterisk; however, please complete all information you have available. If an employee has returned to work, completion of the “Returned to Work Date” is very important!

- **Hire Date:** Enter the Claimant’s Date of Hire.
- **Job Title:** Enter the Claimant’s Job Title.
- **Number of Days Worked per Week (Or Shift Work):** Please enter the number of days the Claimant works in an average week.
- **Wage Rate at Time of Injury:** Enter the Wage the Claimant was receiving at the time he/she was injured.
- **Normally Scheduled Days Off:** Enter any days the Claimant is normally scheduled to be off.
- **Returned to Work Date:** Enter the Date the Claimant returned to work, if applicable.
- **Returned at What Wage:** Enter the Wage the Claimant returned to work at, if applicable.

Once you have completed the required fields, click “Next”.



If you would like to go back to the prior tab, click “Previous” or click on the tab at the top of the page.



INJURY TAB

The information on this page that is required must be as specific as possible.

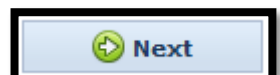
- **Date of Injury:** Enter the Date the Claimant was injured.
- **Time of Injury:** Please select the time of the Claimant's injury.
- **Location of Injury/Accident:** Please enter the location of the accident.
- **County of Injury:** Enter the county where the injury occurred.
- **Date Injury Reported to Employer:** Enter the date when the accident was reported to the Employer.
- **1st Day of Work Missed:** Enter the 1st date the Claimant missed a day of work as a result of the accident.
- **Did Employee Receive Full Pay on Date of Injury? Yes No:** Select the appropriate answer.
- **Did Injury Occur on Employer Premises? Yes/No:** Select the appropriate answer.
- **Type of Injury/Illness:** Please enter the type of injury (contusion, strain, fracture, etc...).
- **Body Part Affected:** Enter the part of body that was injured.
- **How Injury Occurred:** Enter how the injury occurred - be specific but concise (fell down step, etc...).
- **Treating Physician:** Enter the Treating Physician.
- **Initial Treatment Given:** Select the appropriate initial treatment given.
- **Hospital/Treating Facility - Name and Address:** Please enter the name and address where treatment was given - please be specific.
- **Date of Death:** Enter the date the Claimant died, if applicable.

The screenshot shows the 'INJURY TAB' form with the following fields and options:

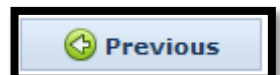
- Date of Injury:** A date picker.
- Time of Injury:** A time picker with AM/PM radio buttons.
- Location of Injury/Accident:** A text input field.
- County of Injury:** A dropdown menu with 'Appling County' selected.
- Date Injury Reported to Employer:** A date picker.
- 1st Day of Work Missed:** A date picker.
- Did Employee Receive Full Pay on Date of Injury?:** Radio buttons for Yes and No.
- Did Injury Occur on Employer Premises?:** Radio buttons for Yes and No.
- Type of Injury/Illness (i.e. contusion, strain, fracture):** A text input field.
- Body Part Affected (i.e. left upper arm, right lower leg, left hip, right eye, low back):** A text input field.
- How Injury Occurred (i.e. fell down step, twisted ankle on curb):** A text input field.
- Treating Physician - Name and Address (Optional):** A text input field.
- Initial Treatment Given (Optional):** Radio buttons for: No Initial Treatment, Minor: By Employer, Minor: Clinical/Hospital, Emergency Room, Hospitalized > 24 hrs.
- Hospital/Treating Facility - Name and Address (Optional):** A text input field.
- Date of Death (If Fatal Injury):** A date picker.

****Note: "Body Part Affected" -- IT IS CRITICAL THAT YOU LIST ALL BODY PARTS AND THE LOCATION ON THOSE BODY PARTS AS THIS IS WHAT THE PHYSICIAN WILL BE PERMITTED TO TREAT (i.e., "left upper arm", "right shoulder", "left ankle", "low back", "upper back", "right eye", "both knees")****

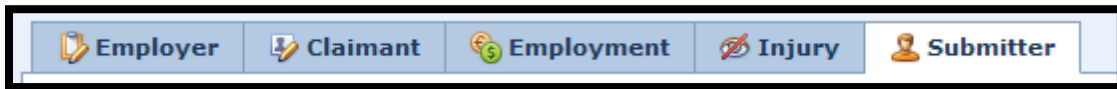
Once you have completed the required fields, click "Next".



If you would like to go back to the prior tab, click "Previous" or click on the tab at the top of the page.

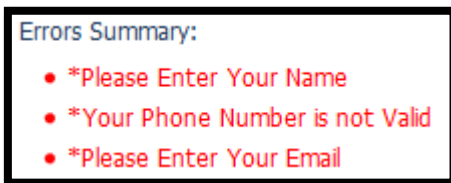


SUBMITTER TAB

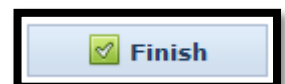


Complete this page as required. The email address on this page will also receive a copy of the WC1.

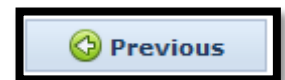
- **Submitter's Name:** Please enter your name.
- **Submitter's Phone Number:** Please enter your phone number in case we have any follow up questions.
- **Is this an Emergency?:** Please indicate if this is an "Emergency", so that immediate attention is given to this claim.
- **Additional Comments:** Please feel free to add any additional comments which may help in the processing of this claim (i.e., "3 employees were injured in this motor vehicle accident").
- **Submission Validation:** You will need to enter the validation code seen in the box. This helps prevent SPAMMING.
- **Errors Summary:** This lets you know any Required Fields you may have missed or overlooked. EXAMPLE:



Once you have completed the required fields, click "Finish".



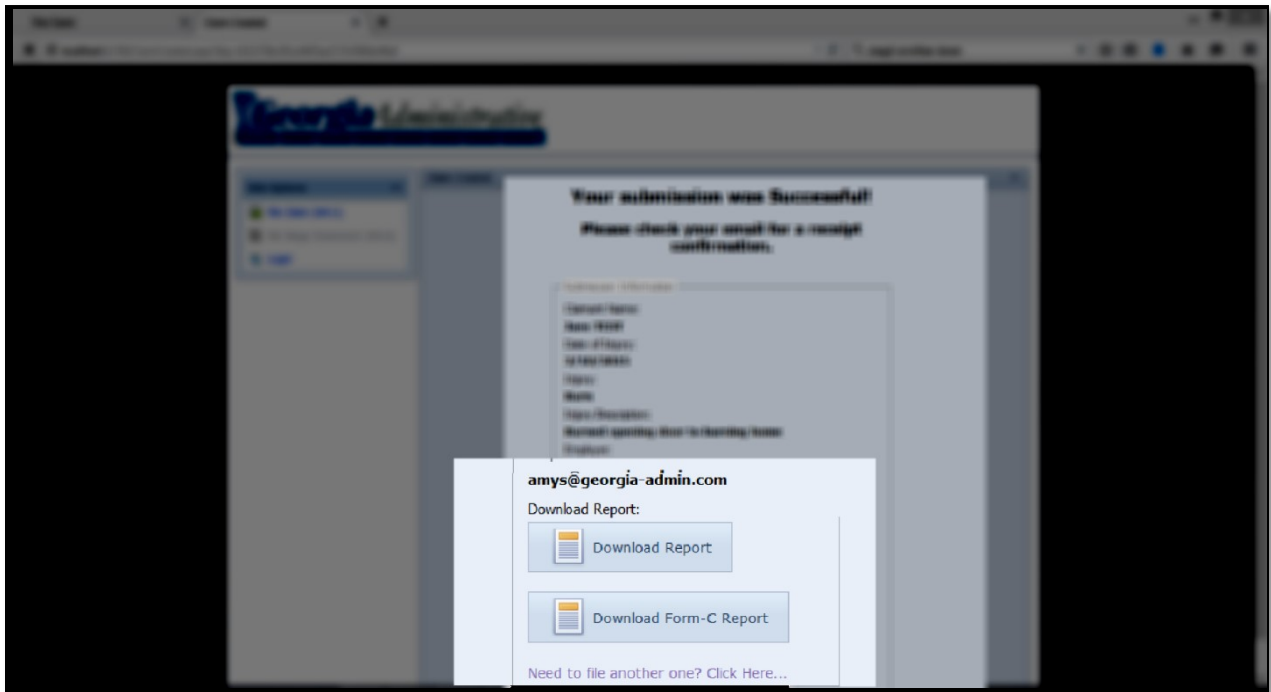
If you would like to go back to the prior tab, click "Previous" or click on the tab at the top of the page.



BE SURE TO CLICK "FINISH" TO SUBMIT YOUR CLAIM

Step 3: Reviewing the claim

- Once you have successfully submitted your claim, you will be directed to this page.



- Click on Download Report to download and view the WC1 PDF Report.
- Click on Download Form-C Report to download the Form-C PDF Report.
- Click on the link below to file another WC1.

Thank You for Using Georgia Administrative Services Online Claim Filing!



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