

Reporting Employee Injuries

What to do when there is an injury on the job.

The campus nurse has been designated as the point of contact to report all work-related employee illnesses/injuries.

This packet contains instructions for nurses to follow to report on-the-job injuries

- For **TRUE** Emergencies, please direct employees to the nearest **Hospital Emergency Room**
 - ✓ **NOTE: Urgent Care centers are not considered Emergency Rooms—send TRUE emergencies to the HOSPITAL ER).**
- For **NON-EMERGENCIES**, employees must seek treatment from an **Alliance Provider** (list attached)
- If an injured employee is **TRANSPORTED BY AMBULANCE** or EMS, promptly notify the BISD Insurance Office at 617-5028 or 617-5029.

What to do:

Have Injured Employee complete and sign the following documents:

1. **Incident Report**—completed/signed the day of the incident
2. **Employee Acknowledgment of Medical Alliance**
3. **Medical Authorization Form**
4. Send above 3 completed/signed forms and checklist to BISD Insurance office
Fax to 617-5180 or email to grumsey@bmtisd.com
5. Notify BISD Insurance Office when an injured employee is missing time
6. Forward a Doctor's Release when an Injured employee returns to work

Distribute to Employee:

1. Copy of completed/signed **Incident Report**
2. Copy of signed **Acknowledgment of Medical Alliance Form**
3. Copy of **Political Subdivision Workers Compensation Alliance** provider listing
4. **Helios First Fill® Prescription Program Form**

Fax or email the original Incident Report ASAP to the BISD Insurance Office.

Injury Reporting CHECKLIST

- Incident Form** *completed/signed by employee*
 - Copy given to Employee
- Acknowledgment of Medical Alliance Form** *signed by employee*
 - Copy given to Employee
 - Medical Alliance Provider List** given to employee
- Medical Authorization Form** *completed/signed by employee*
 - Copy of form given to employee
- OPTUM First Fill**[®] Prescription Form given to employee

- All Forms scanned or emailed to BISD Insurance office:**
 - Incident Form** *(completed/signed by employee)*
 - Acknowledgment of Medical Alliance Form** *(signed by employee)*
 - Medical Authorization Form** *(signed by employee)*
 - Completed Injury Reporting Checklist**

Nurse Signature

Date

Campus

Incident Report

➤ **An Administrator, Supervisor or Nurse must report an on-the-job injury to the *BISD Insurance office* within 24 hours.**

Employee Name: _____
Last First

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ - _____ - _____ Cell: _____ - _____ - _____

Marital Status: S M D W Name of spouse: _____

Date of Birth: ____/____/____ Gender: F M Last 4 of Social: _____

Date of injury: ____/____/____ Time of injury: _____ a.m. _____ p.m.

Occupation: _____ Hire Date: ____/____/____ Wages/hour or day: \$ _____

Are you able to work? Yes No First day unable to work: ____/____/____

Supervisor : _____ When did your Supv. first know of injury: ____/____/____

Work Location/Campus: _____ Supervisor phone number: _____

Campus where injury Occurred: _____

Location injury occurred (stairs, classroom, parking lot, etc.): _____

Describe fully how incident occurred and state what you were doing when injured:

Describe part(s) of body affected: _____
Back Injuries: MUST SPECIFY: **UPPER – MIDDLE – LOWER** (circle)
All other injuries: MUST SPECIFY: **RIGHT** or **LEFT** (circle)

Date this form was completed: _____

Signature of Employee

Signature of Nurse

Reporting only (not seeking treatment at this time)

Campus Nurse Printed Name: _____

Seeking treatment at: _____



TASB RISK
MANAGEMENT FUND

12007ResearchBlvd. • Austin, Texas 78759-2439 • P.O. Box 2010 • Austin, Texas 78768-2010
Tel 800.482.7276 • Fax 800.580.6720 • tasbrmf.org

Administered by the Texas Association of School Boards, Inc.

November 14, 2016

Dear _____ :

At the bottom of this document, you will find a Medical Authorization Release. This release is necessary for us to properly evaluate your workers' compensation claim.

Please read and sign this form, which authorizes the TASB Risk Management Fund to obtain appropriate medical records necessary to complete our investigation. Your prompt return of the authorization form below will help expedite our investigation. After you have signed the authorization, return it to our office in the enclosed envelope.

If you have any questions, call me at 800-482-7276, extension _____. Our office hours are from 8 a.m. to 5 p.m., Monday through Friday.

Sincerely,

Claims Representative

MEDICAL AUTHORIZATION

You are hereby authorized to provide the TASB Risk Management Fund and its representatives any and all medical information relevant to my workers' compensation injury claim. This authorization also includes permission to copy or view all of the hospital notes, records and information, including but not limited to laboratory tests and x-rays, histories, examinations, tests, treatment, consultations and opinions and any and all other information relevant to this claim. Medical information relevant to this claim includes past history of complaints or treatment of any conditions similar to that presented in the claim or other conditions related to the same body part.

To address privacy concerns, HIPAA Rule 45CFR 512(1) specifically authorizes provider disclosure of protected health information without an individual's authorization to the extent necessary to comply with workers' compensation laws.

A copy of this form shall have the same effect as the original.

Signature

Date

Name:
Social Security Number:
Date of Injury:



Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY... TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for TASB Risk Management Fund. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:



If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.



If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.



Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?



1-866-599-5426

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM			
TASB Risk Management Fund		Beaumont ISD	
CARRIER/TPA		EMPLOYER	
INJURED WORKER NAME			
Please provide directly to Pharmacist			
SOCIAL SECURITY NUMBER		DATE OF INJURY (YYMMDD)	
Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com .			

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789. Tmesys is the designated PBM for this patient. This card is not valid for compound medications.			
Tmesys Pharmacy Help Desk			
1-800-964-2531			
	NDC	Envoy	
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	TASBFF		

NOTE: This First Fill card is only valid for your workers' compensation injury or illness.



Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc, dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc, dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."

tmesys®

IMP14-1614-167



Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para TASB Risk Management Fund. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:



Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.



Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.



La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?



1-866-599-5426

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM			
TASB Risk Management Fund	Beaumont ISD		
PORTADORA	EMPLEADOR		
NOMBRE DEL TRABAJADOR LESIONADO			
Please provide directly to Pharmacist			
NUMERO DE SEGURO SOCIAL		FECHA DE AEA LESION (YYMMDD)	
Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.			

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of Injury and SSN combined as follows: YYMMDD123456789.	
Tmesys is the designated PBM for this patient. This card is not valid for compound medications.	
Tmesys Pharmacy Help Desk	
1-800-964-2531	
	NDC Envoy
RxBIN	004261 or 002538
RxPCN	CAL or Envoy Acct. #
GROUP	<u>TASBFF</u>

NOTA: Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.



Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc., dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."

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**EMPLOYEE ACKNOWLEDGMENT OF THE ALLIANCE
DIRECT CONTRACTING PROGRAM**

I have received information that tells me how to get health care under my employer's workers' compensation coverage. If I am hurt on the job and live in a service area described in this information, I understand that:

- 1. I must choose a treating doctor from the Alliance list of doctors designated as treating doctors.
- 2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go to any licensed medical professional within the United States.
- 3. Even though my treating doctor should refer me to a specialist of providers contracted with the Alliance, I understand that I need to verify that the referral doctor is a member of the Alliance provider panel.
- 4. The Texas Association of School Boards Risk Management Fund will pay the treating doctor and other Alliance providers for all health care related to my compensable injury.
- 5. I understand that my medical and/or income benefits may be disputed if I receive health care from a provider other than an Alliance provider without prior approval from the Fund.
- 6. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.
- 7. If I want to change doctors after my first choice, I can do so within the first 60 days of starting treatment, and I can only choose from the Alliance list of providers. A third choice requires approval from my adjuster.

Signature

____/____/____
Date

Printed Name

I live at:
Street Address

City State Zip Code

Name of Employer: BEAUMONT INDEPENDENT SCHOOL DISTRICT

Name of Direct Contracting Program: Political Subdivision Workers' Compensation Alliance (the Alliance)

Direct contracting service areas are subject to change. To locate a treating doctor within your area, visit the PSWCA web site at www.pswca.org or call your adjuster at 800-482-7276.

To be completed by the employer only

Please indicate whether this is the:

- Initial Employee Notification
- Injury Notification (Date of Injury: ____/____/____)

DO NOT RETURN THIS FORM TO THE TASB RISK MANAGEMENT FUND UNLESS REQUESTED.