Employee Injury/Illness Reporting Instructions

CAMPUS - WHAT TO DO WHEN THERE IS AN INJURY ON THE JOB

For Emergencies please direct employee to nearest Emergency Room or Clinic. If possible ensure Employee leaves with ***Verification of Employment for Reported Injury or Illness*** *(Page 4)* ***First Fill Medication Card*** *(Page 5) and contact* ***Risk Management*** *immediately*

- ☐ You must ensure a **First report of Injury** (Page 2) is completed with or without the employee's assistance! Complete and submit the First Report of Injury no later than the next business day to Shawn Gray, Risk Manager.
- ☐ Have the employee sign **Acknowledgement of Medical Alliance** (Page 3)
- ☐ If Employee feels he/she may seek medical treatment complete and give the **Verification of Employment for Reported Injury or Illness** (Page 4) **First Fill Medication Card** (Page 5)
- ☐ Have Employee advise whether he/she wishes to use available leave for any possible lost time due to the on the job injury by completing and signing an **Election of Leave** form. (Page 6)

Email or Fax all signed forms and paperwork by the next business day to:

LaToya Scott, Risk Manager
Phone: 972-429-3073
Fax: 972-941-6073
Email: **LaToya.Scott@wylieisd.net**

Please refer injured employee directly to Shawn Gray for any further questions or issues regarding any workers' compensation injury. Alert Shawn Gray immediately if employee misses any time, returns to work, or if there are any questions or concerns.

To search for primary care physicians in your area go to **the Find A Doctor link** at the Political Subdivision Medical Alliance (www.pswca.org) website.

NOTE: A First Report of Injury must be filed once employee reports or campus is made aware of any on the job injury, illness or incident. Group Insurance does not cover medical treatment for compensable workers' compensation injury. Employees should not pay for medical treatment for a workers' compensation injury.

This form needs to be submitted to WISD Risk Management within 24 hours from the date of the injury.
FAX or SCAN THE COMPLETED FORM TO 972-941-6073.
Original does not need to be mailed.

CARRIER'S CLAIM #

Make a copy of the completed form for the injured employee.

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, Middle Initial)	2. Sex Female ☐ Male ☐	3.Report Type ☐ RECORD ☐ MEDICAL OR LOST TIME
4. Social Security Number Last 4 digits only XXX-XX-	5. Home Phone	6. Date of Birth (mm-dd-yyyy)
7. Does the Employee Speak English? If No, Specify Language YES ☐ NO ☐		
8. Race White☐ Black☐ Asian☐	9. Ethnicity Hispanic ☐ Native American ☐ Other ☐	
10. Mailing Address Street or PO Box		
City State Zip Code County		
11. Marital Status Married☐ Widowed☐ Separated☐ Single☐ Divorced ☐		
12. Number of Dependent Children	13. Spouse's Name	
14. Doctor's Name (That you plan to see for this Workers' Compensation Injury)		
15. Doctor's Mailing Address (Street or PO Box)		
City State Zip Code		

16. Date of Injury* (mm-dd-yyyy)	17. Time Employee Started Work* : am☐ pm☐	18. Time Employee Injury Occurred* : am☐ pm☐
19. Nature of Injury* (Cut, strain, fracture, etc)	20. Part of Body Injured or Exposed*	
21. Specify what activity you were engaged in when Injury/Illness occurred. Describe sequence of events. *		
22. Was employee doing his regular job? YES ☐ NO ☐	23. Worksite Location of Injury (hall, classroom, etc.)*	
24. Address Where Injury or Exposure Occurred - Name of Business if incident occurred on a business site – **Campus Name:** Street or P.O. Box County		
City State Zip Code		
25. Cause of Injury (fall, tool, machine, etc.) *		
26. List Witnesses & Phone Numbers		

27. Return to work date/or expected (mm-dd-yyyy)	28. Did this employee die from this injury? YES ☐ NO ☐	29. Supervisor's Name & Phone	30. Date Reported (mm-dd-yyyy)

Please check all boxes below that apply to the injury:

Nature of Injury		Part of Body Injured			
Abrasion/Scrape		Abdomen		Hand*	
Bruise		Ankle*		Head	
Burn		Arm*		Hip*	
Cut		Back		Knee*	
Dislocation		Chest		Leg*	
Head Injury		Elbow*		Mouth	
Fracture		Ear*		Nose	
Laceration		Eye*		Neck	
Mash/Pinch		Face		Shoulder*	
Puncture		Finger**		Toe**	
Shock		Foot*		Wrist*	
Sprain		*Specify which hand, arm, foot, leg, etc.	**Check:**		
Strain		**If finger or toe, indicate which one.	☐ Left ☐ Right		
Other			☐ Both		

_____ _____

Principal/Manager Signature **Date**

Employee Acknowledgement 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: Wylie ISD – Collin County

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 **pswca.org** or call your adjuster at 800.482.7276.

WYLIE ISD
951 S. Ballard Ave. Wylie, Texas 75098
972-429-3000
www.wylieisd.net

Verification of Employment for a Reported Workers' Compensation Injury or Illness

Employee Name: _____ Date of Injury: _____

Date of Birth: _____ Last 4 Digits of SSN: xxx-xx-_____

Nature of Work Related Injury or Illness (What body part is injured and what is the injury? or What is the illness?):

_____

Wylie ISD's workers' compensation coverage provider is the Texas Association of School Boards Risk Management Fund which is a member of the Political Subdivision Workers' Compensation Alliance (the Alliance). **For emergencies, an injured employee may go to the nearest emergency room**. Otherwise, all other treatment must be from an Alliance Provider listed at www.pswca.org.

TASB Risk Management Fund:
PO BOX 2983, Clinton, IA 52733-2983
Phone: 800.732.0153
Fax: 732.212.7009

eFill Information
Clearinghouse: WorkComp EDI
Clearinghouse website: www.workcompedi.com
TASB's Payer ID: WR902

Pre-Authorization
Phone: 800.482.7276 ext. 9908
Fax: 888.777.8272

Campus/Department Authorization (signature): _____ Phone Number: _____

Campus/Department Authorization (printed name): _____Date: _____

Post-Accident Drug/Alcohol Test Requested: Yes ☐ No ☐
(Drug/alcohol testing is directed only by the Employer and must be billed separately and directly to Wylie ISD.)

Providers please submit Work Status Reports and all job description inquiries to:
Wylie ISD Risk Management
Phone: 972-429-3073
Fax: 972-941-6073
Email: LaToya.Scott@wylieisd.net

For a full list of Alliance Providers please visit www.pswca.org

Campus/Department: Please give this form along with the Optum Rx Card to the injured employee.

OPTUM®

PO Box 152539
Tampa, FL 33684-2539

TASB™ RISK FUND

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

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. 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 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

OPTUM®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

TASB Risk Mgmt. Fund — CARRIER/TPA

Wylie ISD-Collin County — 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.

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.

tmesys®

IMP14-1813-37

EMPLOYEE CHOICE TO USE PAID LEAVE
WITH WORKERS' COMPENSATION BENEFITS

Name _____ **Employee number** _____

Position _____ **Department/Campus** _____

Employee Choice:
I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I also understand that the district will continue to pay its contribution toward the cost of my group health insurance coverage (if applicable) as long as I am on **paid** leave and/or family and medical leave (FMLA). I further understand that I will be responsible for paying all health insurance premiums if I am on **unpaid** leave that is not FMLA leave. I choose the following option:

- ❑ I choose to use only _____ days of available paid leave at this time.
- ❑ I choose to use all available paid leave. I understand that I will not receive workers' compensation weekly income benefits until I have exhausted all of my paid leave or to the extent that paid leave does not equal my pre-illness or pre-injury wage.
- ❑ I choose **not** to use any available paid leave at this time. **I understand that I will not receive any regular salary payments from Wylie ISD while receiving weekly income benefits under workers' compensation.** No available paid leave will be deducted from my leave balance. I further understand that by selecting this option, I will only receive workers' compensation wage benefits for any absences resulting from my work-related illness or injury, unless and until I communicate to the district a change in my decision.

_____ _____
Employee signature Date

***Risk Management Office Use:**
This employee is absent from duty because of a job-related illness or injury beginning on _____ *(date of first absence attributable to illness or injury)*. If eligible, workers' compensation insurance may begin paying a percentage of the employee's current wages on the eighth day of absence from duty if an extended absence is required.

_____ _____
Risk Management Staff Signature Date

For all employees:
Amount of leave paid to employee: $_____

Daily Rate: $_____

Period of payment:
From:_____thru_____

For_____days

For hourly employees only:
Hourly rate: $_____

Number of hours paid:_____