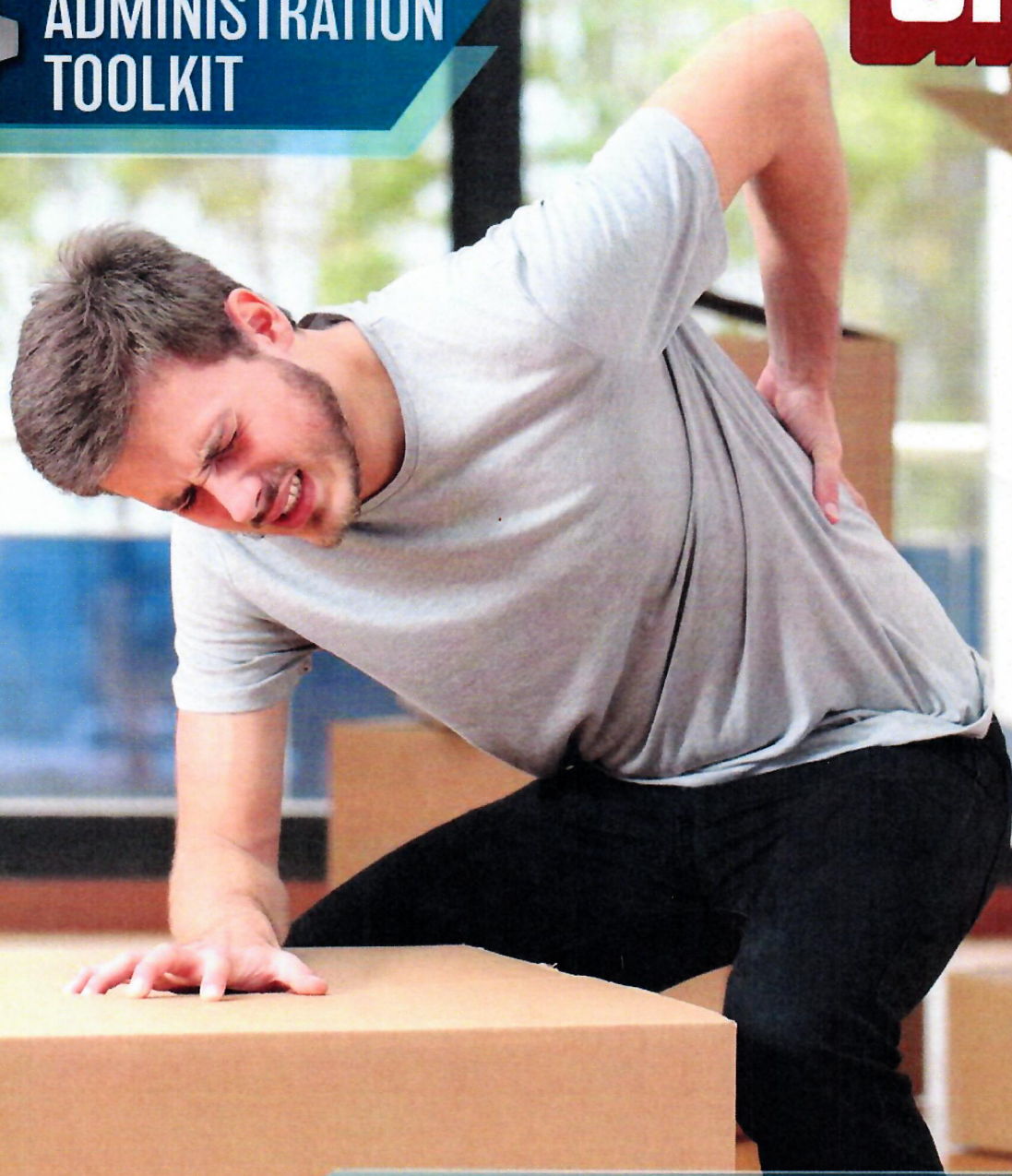


Workers' Comp New Injury Packet



ADMINISTRATION
TOOLKIT

CAS



WRITTEN BY CLAIMS ADMINISTRATIVE SERVICES

Table of Contents

Employer's Checklist	03
Employee's Injury Report: ENGLISH	04
Employee's Injury Report: SPANISH	06
HIPAA Authorization Form	08
Employee Rights & Responsibilities	09
Prescription Information	11
Pharmacy Card FAQ's	12
Injured Employee Checklist	13
Disclaimer	14

Employer's Checklist

When a new injury occurs, it is important for all employers to have clear instructions on how to fill out forms, file paperwork, and what to give the injured employees. Use this guide to help your district complete tasks regarding the injured employee. Check off each task when it is completed and sign the bottom of this form. Keep this information for your records.

HAVE INJURED EMPLOYEE FILL OUT:

- ☐ Employee's Injury Report
- ☐ HIPAA Authorization Form

(To help expedite the claims process, these forms can be sent to: ClaimsMail@cas-services.com)

GIVE INJURED EMPLOYEE:

- ☐ Employee Rights & Responsibilities
- ☐ Workers' Compensation Pharmacy Information
- ☐ myMatrixx Pharmacy Card Questions & Answers
- ☐ Injured Worker's Checklist

NEW INJURY PACKET COMPLETED BY

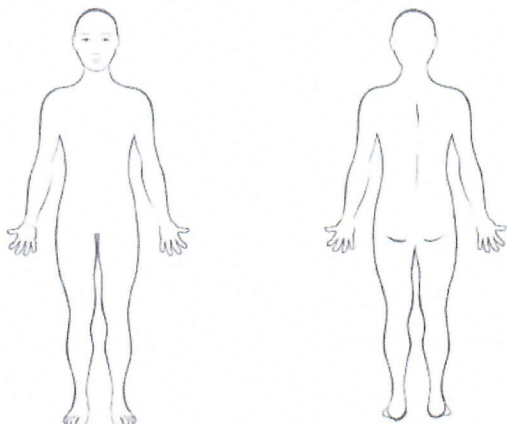
EMPLOYEE NAME	
EMPLOYEE SIGNATURE	
DATE	

Employee's Injury Report

ENGLISH

This form must be completed in detail and signed by the injured employee.

EMPLOYEE INFORMATION	
Name	
Job Position Department	
Social Security Number (Last 4 digits only)	XXXX-XX-
Date of Birth	
Address (Street, City, State, County, Zip)	
Phone Number	
Supervisor's Name	
Location of Accident	
Job Title at Time of Injury	
How Long in Current Position	_____ Years _____ Months
Date of Hire	
DETAILS OF THE INJURY	
Date of Injury	
Time of Injury	
Date You First Lost Time	
Where in the workplace did your injury occur?	
Describe in detail how your injury occurred.	
What safety equipment were you using at the time of the accident?	
What can be done to prevent this type of injury in the future?	
When were you first aware of this injury?	
When did you first notify your supervisor of your injury?	
What part of your body is injured?	
Describe the injury.	

On the diagram provided, please circle the part(s) of your body where you are experiencing pain due to this injury.	
Did anyone witness your accident? List the names of any witnesses.	
Was anyone else injured in this accident? List the names of any other injured people.	
In the incident that caused your injury, was there damage to any property or equipment? Describe any damage.	

- ✓ I certify that the information contained in this report is true and correct.
- ✓ I understand that any falsification of information regarding an on the job injury may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes.
- ✓ I hereby authorize the release of all medical records relating to the above noted incident to my employer, his agent or insurance company.

EMPLOYEE NAME	
EMPLOYEE SIGNATURE	
DATE	

- ✓ I certify that the above employee has acknowledged to me that he/she understood all questions and signed and dated this form in my presence this date.

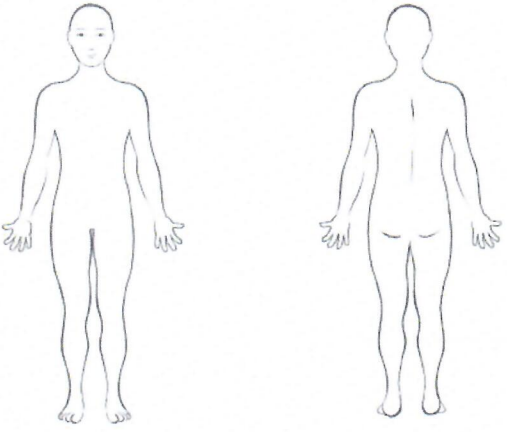
WITNESS NAME	
WITNESS SIGNATURE	
DATE	

Informe de Lesión de Empleado

SPANISH

This form must be completed in detail and signed by the injured employee.

Información de Empleados	
Nombre completo	
Departamento en el que labora	
No. de seguro social (últimos 4 dígitos)	XXXX-XX-
Fecha de nacimiento	
Domicilio (Calle, Ciudad, Estado, Condado, C.P.)	
Teléfono donde se le puede localizar	
Nombre de superviso	
Lugar del accidente	
Puesto de trabajo cuando ocurrió la lesión	
Antigüedad en puesto actual	_____ Years _____ Months
Fecha de contratación	
Detalles de la lesión	
Fecha de la lesión	
Hora de la lesión	
Fecha de inicio de la incapacidad	
¿En qué parte de su trabajo ocurrió la lesión?	
Describa detalladamente cómo ocurrió su lesión.	
¿Qué equipo de seguridad usaba cuando ocurrió el incidente?	
¿Qué se puede hacer para evitar este tipo de lesión en el futuro?	
¿Cuándo identificó la lesión por primera vez?	
¿Cuándo informó por primera vez de la lesión a su supervisor?	
¿Qué parte de su cuerpo se lesionó?	
Describa la lesión.	

En el diagrama a continuación, por favor marque con un círculo la parte o partes de su cuerpo en las que presenta dolor por esta lesión..	
¿Alguien presencié el incidente? Escriba los nombres de los testigos.	
¿Alguien más resultó lesionado en este incidente? Escriba los nombres de cualquier otro lesionado.	
En el incidente que ocasionó su lesión, ¿hubo daños a la propiedad o a los equipos? Describa los daños.	

- ✓ Declaro que la información aquí presentada es correcta y verdadera.
- ✓ Comprendo que la falsificación de información con respecto a una lesión laboral puede castigarse con alguna medida disciplinaria o demanda judicial de acuerdo con las Leyes Penales Estatales.
- ✓ Por medio del presente formulario, autorizo que los registros médicos relacionados con el incidente aquí descrito sean compartidos con mi empleador, su agente o compañía de seguros.

NOMBRE COMPLETO DEL EMPLEADO	
FIRMA DEL EMPLEADO	
FECHA	

- ✓ Doy fe de que el empleado cuyos datos aquí se han asentado me ha indicado que comprendió todas las preguntas y que firmó y fechó este formulario en mi presencia en este día.

NOMBRE COMPLETO DEL TESTIGO	
FIRMA DEL TESTIGO	
FECHA	

HIPAA Authorization Form

I, _____, (Name) _____, (Date of Birth) _____, (SSN) _____ authorize the disclosure of my protected health information* as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws**, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below):
 - ✓ **All healthcare providers who have provided healthcare to me.**
2. I authorize the following person(s) and/or organizations to receive my protected health information as disclosed by the person(s) and/or organization(s) above.
 - ✓ **Claims Administrative Services, Inc.**
P.O. Box 7500, Tyler, Texas 75711
 - ✓ **Texas Department of Insurance - Division of Workers' Compensation**
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609
 - ✓ **Others:** _____
3. Specific description of the protected health information that I authorize for disclosure:
 - ✓ **Any and all records regarding my health, including medical histories, consultations, examinations, prescriptions, diagnosis, tests, reports or treatments.**
 - ✓ **I further specifically authorize the disclosure of psychotherapy notes, if any.**
4. The purpose for requesting this information is for use by the carrier to evaluate, adjust, describe, or report matters about my health to persons entitled to receive this information.
5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.
6. I understand that treatment and payment for my treatment are not conditioned on my agreement to this authorization.
7. I understand that the release of protected health information to a non-covered entity may invalidate its protection.
8. I understand that my express consent is required to release any healthcare information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use, you are specifically authorized to release all healthcare information related to such diagnosis, testing or treatment.
9. This authorization expires on one year from the date of authorization, or the date that my workers' compensation claim is finally closed, whichever occurs first.
10. I have had the opportunity to read and consider the contents of this authorization. I confirm that this authorization is a true and correct statement of my intention to permit the disclosure of my PHI as described in this authorization.

EMPLOYEE NAME	
EMPLOYEE SIGNATURE	
DATE	

*Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to 1) the past, present or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508 **These laws apply to health plans, health care providers, and health care clearinghouses.

TEXAS WORKERS' COMPENSATION SYSTEM

As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel. This assistance is offered at local offices across the State. These local offices also provide other workers' compensation system services from the Texas Department of Insurance (TDI). TDI is the state agency that administers the system through the Division of Workers' Compensation.

- ✓ You can contact the Office of Injured Employee Counsel by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). Also, more information is available on the Internet at: www.oiec.state.tx.us
- ✓ You can contact the Division of Workers' Compensation by calling the toll-free telephone number 1-800-252-7031. More information about the Division of Workers' Compensation is available on the Internet at: <http://www.tdi.state.tx.us/wc/indexwc.html>

YOUR RIGHTS IN THE TEXAS WORKERS' COMPENSATION SYSTEM

1. **You may have the right to receive benefits.** You may receive benefits regardless of who was at fault for your injury with certain exceptions, such as:
 - ✓ You were intoxicated at the time of the injury.
 - ✓ You injured yourself on purpose or while trying to injure someone else.
 - ✓ You were injured by another person for personal reasons.
 - ✓ You were injured by an act of God.
 - ✓ Your injury occurred during horseplay.
 - ✓ Your injury occurred while voluntarily participating in an off-duty recreational, social, or athletic activity.
2. **You have the right to receive medical care to treat your workplace injury or illness.** There is no time limit to receive this medical care as long as it is medically necessary and related to the workplace injury.
3. **Choosing a treating doctor:**
 - ✓ If you are in a Workers' Compensation Health Care Network (network), you must choose your doctor from the network's treating doctor list.
 - ✓ If you are not in a network, you may choose any doctor who is willing to treat your workers' compensation injury.
 - ✓ If you are employed by a political subdivision (e.g. city, county, school district), you must follow its rules for choosing a treating doctor.
 - ✓ It is important to follow all the rules in the workers' compensation system. If you don't follow these rules, you may be held responsible for payment of medical bills.
4. **You have the right to hire an attorney at any time to help you with your claim.**
5. **You have the right to receive information and assistance from the Office of Injured Employee Counsel at no cost.**
 - ✓ Staff is available to answer your questions and explain your rights and responsibilities by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432) or visiting any Division of Workers' Compensation/Office of Injured Employee Counsel local field office.
6. **You have the right to receive ombudsman assistance if you do not have an attorney and a dispute resolution proceeding about your claim has been scheduled.** An ombudsman is an employee of the Office of Injured Employee Counsel. Ombudsmen are trained in the field of workers' compensation and provide free assistance to injured employees who are not represented by attorneys. At least one Ombudsman is located in each local field office to assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot sign documents for you, make decisions for you, or give legal advice.

7. **You have the right for your claim information to be kept confidential.** In most cases, the contents of your claim file cannot be obtained by others. Some parties have a right to know what is in your claim file, such as your employer or your employer's insurance carrier. Also, an employer that is considering hiring you may get limited information about your claim from the Division of Workers' Compensation.

YOUR RESPONSIBILITIES IN THE TEXAS WORKERS' COMPENSATION SYSTEM

1. **You have the responsibility to tell your employer if you have been injured at work or in the scope of your employment.** You must tell your employer within 30 days of the date you were injured or first knew your injury or illness might be work-related.
2. **You have the responsibility to know if you are in a Workers' Compensation Health Care Network (network).** If you do not know whether you are in a network, ask the employer you worked for at the time of your injury. If you are in a network, you have the responsibility to follow the network rules. Your employer must give you a copy of the TDI network rules. Read the rules carefully. If there is something you do not understand, ask your employer or call the Office of Injured Employee Counsel. If you would like to file a complaint about a network, call TDI's Customer Help Line at 1-800-252-3439 or file a complaint online at <http://www.tdi.state.tx.us/consumer/complfrm.html#wc>
3. **If you worked for a political subdivision (e.g. city, county, school district) at the time of your injury, you have the responsibility to find out how to receive medical treatment.** Your employer should be able to provide you with the information you will need in order to determine which health care provider can treat you for your workplace injury.
4. **You have the responsibility to tell your doctor how you were injured and whether the injury is work-related.**
5. **You have the responsibility to send a completed claim form (DWC-41) to the Division of Workers' Compensation.** You have one year to send the form after you were injured or first knew that your illness might be work related. Send the completed DWC-41 form even if you already are receiving benefits. You may lose your right to benefits if you do not send the completed claim form to the Division of Workers' Compensation. Call 1-800-252-7031 or 1-866-393-6432 for a copy of the DWC-41 form.
6. **You have the responsibility to provide your current address, telephone number, and employer information to the Division of Workers' Compensation and the insurance carrier.**
7. **You have the responsibility to tell the Division of Workers' Compensation and the insurance carrier any time there is a change in your employment status or wages. Examples include:**
 - ✓ You stop working because of your injury.
 - ✓ You start working.
 - ✓ You are offered a job.

Prescription Information

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions. Day supply is limited to 7 days for any new injury.

EMPLOYER'S NAME	
EMPLOYEE NAME	
GROUP #	10602583
MEMBER ID (SSN)	
DATE OF INJURY	
PROCESSOR	myMatrixx
BIN NUMBER	014211
EMPLOYER SIGNATURE	
EMPLOYER PHONE NUMBER	
DATE	

EMPLOYEE

CAS 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 60,000 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 the above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only. Document only valid if signed and dated by employer above.
- ✓ 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.

What is this card?

This card is for your workers' compensation prescription needs. Please take this card to the pharmacy when you are filling medications for your work-related injury.

Why did I receive this card?

You received this card due to an injury that occurred on the job.

What if I am not currently taking any medications due to the injury?

Please put the card in a safe place in case you start taking medications for your current injury.

When should I use this card?

Any time you need to fill a medication for your work-related injury.

Are all medications pre-approved?

Your insurance company may have pre-selected medications that will go through without authorization. If you drop off a prescription at the pharmacy and it rejects for any reason, the pharmacy should call us and we will call your insurance company for approval. If you would like to know the types of medications that are pre-approved before going to the pharmacy, please call **877-804-4900**, and a customer service representative will be happy to assist you.

Can my family members use this card?

No, this is only for your work-related injury.

What should I do if there is a problem with the card when I take it to the pharmacy?

Your pharmacy should call us with any problems they are having with the card. If for ANY reason they do not call us, or if you have any questions regarding your work-related medications, please call our customer service team at **877-804-4900**.

Are you my workers' compensation insurance company?

No, we are contracted by your workers' compensation insurance company to handle all of your work-related prescription needs.

What happens if my medication doesn't provide relief from my symptoms or pain?

You should contact your doctor or pharmacist to verify that the medication prescribed for your pain is the most appropriate for your condition.

Should I tell my doctor about other medications I am taking not related to my work injury?

Yes. It is very important that your physician and pharmacist know ALL the medications you are currently taking. Some medications may counter the effect of other medications you are taking and some may even be harmful or life-threatening when taken together.

Can I talk to one of your pharmacists if I have a question?

Yes, our pharmacists care available to answer all of your medication-related questions.

For any questions, call myMatrixx at: 877-804-4900

Injured Employee Checklist

The following information will help you recover from your injury, resume your normal work activities, and return to work as soon as possible.

GIVE YOUR DOCTOR:

- ☐ Workers' Compensation Claim Number
- ☐ Division of Workers' Compensation Claim Number
- ☐ Employer's Name & Phone Number
- ☐ Information Regarding Your Job or Other Work Opportunities
- ☐ Insurance Adjuster's Name & Phone Number

BE SURE TO:

- ✓ Go to all your medical appointments.
- ✓ Follow your doctor's directions carefully.
- ✓ Talk to your doctor to see if you can continue to work, even if you have some restrictions.
- ✓ Share a copy of your job description to help your doctor understand your specific work demands.
- ✓ Talk to your doctor to make sure you completely understand what you can and cannot do while you are recovering.
- ✓ Comply with the medical restrictions set by your doctor at home and at work.

YOU & YOUR EMPLOYER:

- ✓ Make sure you have received and reviewed your 'Employee Rights and Responsibilities'.
- ✓ Follow all employer policies and requirements associated with your workers' compensation injury.
- ✓ Be sure to keep your employer informed and up-to-date on your recovery and current abilities.
- ✓ Talk to your employer about work that you could continue to do during your recovery.
- ✓ Notify your employer immediately if your work status changes.

GETTING BACK TO WORK:

- ✓ Communicate with your employer so that you can return to productive work as soon as medically possible.
- ✓ Contact your adjuster when your work status changes to ensure that appropriate benefit payments are made.
- ✓ Help your employer determine what additional work you could take on as your condition improves.
- ✓ If work within your restrictions is not immediately available, keep checking back with your employer. As you continue to recover, the situation may change.
- ✓ Be sure to let your employer know about any concerns or problems you might have related to your health and job assignments.

By continuing to work during your recovery, healing will likely progress more quickly and effectively than if you perform no work at all for an extended period of time. You will also have a much more productive mindset that can in fact help speed your recovery.



Claims Administrative Services, Inc.
"Our reputation for excellence is no accident."

501 Shelley Drive, Tyler, TX 75701

800.765.2412

www.cas-services.com

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