Work Injury / Workers Compensation Packet

At any time you are injured in the course of your employment, you must report the injury as soon as possible. This packet of information includes directions on how to report the injury, the necessary forms for you to complete and some additional information about Workers Compensation.

Filing an Injury/Illness Report

Step 1

Submit a claim by calling Travelers at 800-832-7839. Have your B number ready.

Step 2

Contact Nurse on Call (24x7 Nurse Line for all healthcare needs). Contacting a Nurse on Call is not required but strongly suggested. Please contact the nurse through your healthcare plan:

Dean Nurse 800-576-8773
GHC Nurse 855-661-7350

Step 3

If you seek medical care, ensure your doctor(s) complete the **Work Status Report/Medical Services Form** at each visit. Return the form to the Benefits Division (FAX: 608-204-0346). Additionally, complete the **Medical Authorization Release Form** and return it to Travelers (FAX: 877-786-5567) to ensure your medical bills are paid.

What's Next?

Watch for an email from the Benefits Division and from Travelers with additional information about your injury/illness.

Seeking Medical Treatment

- Generally, you can choose to see any doctor authorized by Workers Compensation.
- Advise your doctor that you have a work-related injury, and tell them you work for the Madison Metropolitan School District. Do not pay for your care yourself or use other health insurance. Be sure to return the **Medical Authorization Release Form** to Travelers to ensure payment of insurance claims.
- Medical reports are necessary for your injury. Provide your doctor(s) with the **Work Status Report/Medical Services Form** and have it completed at each doctor appointment and returned to the Benefits Division.
- Nurse on Call services are available to help you if you are injured at work. This confidential and free program allows you to speak to a registered nurse to help you through your injury.

Lost Wages

- You may be entitled to a portion of your lost wages under Workers Compensation law.
- Any work time that is missed in relation to a worker's compensation claim will be paid through your own available personal time until an approval (compensability) ruling has been given by the workers compensation insurance carrier. If the claim is accepted by the carrier, all time used that has proper documentation will be credited back to you.
- All time away from work, including any related appointments, and/or notice of restrictions must be documented in writing by a licensed physician/medical doctor. Notes from a nurse practitioner (APNP) or physician's assistant (PA-C) addressing time off or restrictions will not be accepted. All notes must be signed by a licensed physician/medical doctor.
- Postdated notes for lost time will not be accepted and absences may not be paid.
- Please schedule doctor appointments outside of your scheduled work time when feasible.

Returning to Work

- When you are able to return to work, please provide the doctor completed **Work Status Report/Medical Services Form** to the Benefits Division.
- MMSD will make a reasonable effort for you to return to work as soon as possible, even with light duty/work restrictions. Restrictions are accommodated even when they are outside your regular scope of work, whenever possible.
- If your doctor releases you back to work and MMSD is able to accommodate any restrictions and you do not return, any salary/benefits continuation may end.

Contact Information

- MMSD: Phone: 608-663-1692 / Fax: 608-204-0346
- Travelers: (Workers Compensation Carrier): 800-842-6172 / Fax: 877-786-5567

MADISON METROPOLITAN SCHOOL DISTRICT
WORK STATUS REPORT/MEDICAL SERVICE FORM

LIGHT DUTY WORK WILL BE ACCOMMODATED FOR ALL CONDITIONS

Please reach out to Workers Compensation Specialist at (608) 663-1745 with any questions or concerns

Fax Immediately to: 608-204-0346 (Custodians please also fax to 608-204-0374)

Directions: You are required to notify your treating provider that MMSD will accommodate all light duty work. To expedite prompt claim handling, this complete form is to be returned to the Madison Metropolitan School District either on the same day of your appointment. Be sure to give this form to your supervisor and request that the supervisor forward the paperwork to the Benefits Division.

EMPLOYER INFORMATION	
Madison Metropolitan School District	Phone: 608-663-1692
545 W Dayton Street, Room 133, Madison, WI 53703	Fax: 608-204-0346

EMPLOYEE INFORMATION (to be completed by the employee)			
Name			
Home/Cell Phone		Date of Birth	
B Number		Social Security Number (required)	
Date of Injury		Time of Injury	am/pm

MEDICAL INFORMATION (to be completed by the treating licensed physician/medical doctors) LIGHT DUTY WORK WILL BE ACCOMMODATED FOR ALL CONDITIONS					
Treatment Received At	☐Clinic ☐Urgent Care ☐Emergency Room				
Date of Exam		Time of Exam		Date of Follow Up	
Diagnosis					
Work Capabilities	☐**Full duty** as of _____(date) ☐**Light Duty Capabilities** through _____(date)				
	Walking: ☐ Full abilities ☐ 4-7 hours ☐ 1-4 hours ☐ Under 1 hour **Lifting:** ☐ 30+ lbs ☐ 21-30 lbs ☐ 11-20 lbs ☐ 0-10 lbs	**Standing:** ☐ Full abilities ☐ 4-7 hours ☐ 1-4 hours ☐ Under 1 hour **Limited Ability:** ☐ Hold Objects ☐ Grip ☐ Type/Keyboard ☐ Other_____ _____	**Sitting:** ☐ Full abilities ☐ 4-7 hours ☐ 1-4 hours ☐ Under 1 hour **Limited Ability:** ☐ Bend ☐ Squat ☐ Kneel ☐ Other_____ _____	**Climbing:** ☐ Full abilities ☐ 4-7 hours ☐ 1-4 hours ☐ Under 1 hour **Environmental Exposure:** (ex. heat, cold, lights, etc.) (please specify) _____ _____	**Traveling:** Public Transit ☐ Yes ☐ No Drive Vehicle ☐ Yes ☐ No **Potential Side Effects:** from medications that could impact RTW (please specify) _____ _____
	☐**Other**_____ through _____(date) Comments:				
Treatment Plan	Expected healing time: Days_____ Weeks_____ Months_____ Other_____ ☐ Must return for re-evaluation on _____(date) ☐ To receive PT/OT services at the rate of _____ time per week for _____ weeks ☐ Inpatient surgery scheduled for _____ at ____:_____ ☐am ☐ pm ☐ Outpatient surgery scheduled for _____ at ____:_____ ☐am ☐ pm ☐ No further care required. Discharge as of _____(date)				
Physician Name		Facility Name			
Facility Address		Facility Phone Number			
Physician Signature		Date			

Travelers Insurance PO Box 3205 Naperville, IL 60655 800-832-7839

WORKERS COMPENSATION MEDICAL AUTHORIZATION RELEASE FORM

The provision of your social security number is mandatory under Wisconsin Statutes and will be used to identify the claimant. Failure to provide it may result in penalties or delayed payment of benefits.
Personal information you provide may be used for secondary purposes [(Privacy Law, s. 15.04(1)(m)].

By law, all health care providers must provide to any employee, employer, worker's compensation insurer or their representative any information reasonably related to any alleged work injury. However, determining the relationship of prior medical records to a work injury can be difficult and time-consuming. Therefore, to assist in the timely investigation of your claim, this document authorizes the health care provider to release medical information without attempting to determine the extent of its relationship to your alleged work injury.

You are not required to sign this document. You may refuse to sign this document without jeopardizing your right to collect worker's compensation benefits. However, by assisting in the investigation of your claim, you are likely to receive benefits quicker and have bills paid quicker than if you refuse to authorize the release of medical information.

Health Care Provider Name		Street Address	
P. O. Box	City	State	Zip Code
Patient (Employee) Name		Employer Name	
Patient Social Security Number	Patient Birth Date	WC Claim No.	

The patient named above hereby authorizes the health care provider named above to disclose all records checked below in its possession relating to the patient's health, treatment and evaluation to:

Name and Address of Party Authorized to Receive Protected Information

or its designated representatives, and to furnish to them a legible, certified duplicate of all records, writings, reports, test results and x-rays in its possession containing such information. This authorization includes *all* records, reports, correspondence, or other materials in the possession of the health care provider authorized, even if those materials were not generated by the health care provider, and the redisclosure of such materials is hereby authorized. This release is for use in the investigation, preparation, evaluation, and/or hearing of the worker's compensation claim described above.

Physical and Other. Release all records, correspondence, and any other information from whatever source regarding the patient's physical and mental health, drug and alcohol abuse, HIV and AIDS tests, treatment, and evaluation including, but not limited to, any made or provided by any physician, psychiatrist, psychologist, nurse, chiropractor, osteopath, dentist, physical therapist, hospital or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited Wis. Stat. §§ 51.30, 146.025, 146.81 and 146.82, 42 C.F.R., Chap. 1, subpart C, § 2.31 and 45 C.F.R. § 164.508.

Patient Signature (or Person Authorized to Sign for Patient) — for Physical and Other:

Patient Signature (or Person Authorized to Sign for Patient):	Date:

WKC-9488-E (R. 12/2003)

In signing this consent form, I acknowledge that I understand that:

- I am authorizing release of the records and information listed above.
- I am waiving any privilege that may otherwise prevent disclosure of the records and information listed above.
- I understand that the health care provider named above, whom I am authorizing to disclose my protected health information, may not condition my treatment, payment, enrollment or eligibility for benefits (if applicable) on whether I sign this authorization, except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.
- I may revoke this authorization at any time by a written request to the party authorized above to receive information, except that the party authorized above to receive such information may rely upon any personal health information received before the revocation of this authorization.
- I may obtain a copy of the disclosed records and information, upon written request to the party authorized above to receive information, at no charge to me.
- My personal health information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal law. My personal health information may be released to any of the following: the employer, the worker's compensation insurer, the Department of Workforce Development, other parties to this matter or their attorneys; the Labor and Industry Review Commission; any court on any action or proceeding relating to this matter; experts retained or consulted by any party; and any of their agents, employees, or representatives. I specifically authorize and consent to any such disclosure and redisclosure.
- I am entitled to a copy of this consent form after I sign it.

If you have any questions about this document, you should contact the Worker's Compensation Division at (608) 266-1340. You should not sign this document if the name of the health care provider is blank.

This consent is subject to revocation at any time. If not revoked, this consent is effective for two (2) years from date signed. This authorization expressly waives any requirement that it must be used within a certain number of days after the date of signing, or that it must be dated within any time period before the date it is used. This authorization shall also extend to records of future treatment, after the date of signing of this authorization, as long as such treatment occurs while this authorization is still in effect. A photocopy copy shall be as valid as the original.

Patient Signature (or Person Authorized to Sign for Patient):	Date:
If not signed by patient, authority/designation to sign is based on the fact that the patient is: ☐A minor ☐Incompetent ☐Disabled ☐Deceased ☐Other:	