Workers' Compensation Claims Packet

ELLICOTT SCHOOL DISTRICT 22

Designated Provider List Notification Letter
For An Injured Worker

To: _____

From: **Ellicott School District - HR**

Date: _____

Subject: Designated Provider List Notification Letter for an Injured Worker

I am sorry to learn that you have been injured. To make sure you receive the care you need, we are filing a claim with our workers' compensation insurance carrier, Pinnacol Assurance. Pinnacol will contact you with your claim number and additional information. In the meantime, you should see one of the medical providers we have selected to treat our injured employees. These medical providers specialize in on-the-job injuries, and I want you to have the best possible care.

1. Name: Concentra Medical Center-North
Address: 5320 Mark Dabling Blvd Ste 100
City, State & Zip: Colorado Springs CO 80918
Phone: 719-592-1584

2. Name: UC Health Occupational Health Clinic
Address: 11605 Meridian View Ste 184
City, State & Zip: Falcon, CO 80831
Phone: 719-364-9561

3. Name: Concentra Medical Center-South
Address: 2322 S Academy Blvd
City, State & Zip: Colorado Springs CO 80916
Phone: 719-390-1727

4. Name: Colorado Occupational Medical
Address: 3910 S Carefree Cir Ste B
City, State & Zip: Colorado Springs CO 80917
Phone: 719-457-6001

Please contact one of these medical providers to be seen as soon as possible. After your first appointment, please follow up with me so we can review your medical status and work capabilities.

The respondent's representative is our workers' compensation insurance company, Pinnacol Assurance. Please see the contact information below.

Pinnacol Assurance
7501 E. Lowry Blvd.
Denver, CO 80230-7006
303.361.4000 or 800.873.7242

If you have questions, please contact me. My goal is to ensure that you get the care you need to recover quickly and return to work as soon as possible.

Organization Name and Phone: **Ellicott School District** - 719-683-2700

Address: 322 S Ellicott Hwy

City, State & Zip: Calhan CO 80808

Employer's Representative for Workers' Compensation:

Name: Donna Plowman - HR

Phone: 719-683-2700 ext. 4418

☐ Hand-delivered on:_____

☐ Mailed to injured worker on:_____

_____

Employer's signature

_____ _____

Employee's signature **Date**

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY

Employee's name (first, middle, last)	Social Security#	D Male D Female	Employee's home phone# ( )	OSHA Log#
Employee's street address	City	State	Zip code	
Birth date / /	Marital status D Married D Separated D Single D Unknown	Date of hire / /	Occupation	Employment status D Full time D Part time D Other D Unknown	For Division use only
Employer's name: Ellicott District 22	Employer's Federal ID#84-6001187	Employer's phone#	SOI
Employer's mailing address 322 S Ellicott Hwy	City Calhan	State CO	Zip code 80808	POB
Average weekly wage at time of injury $	Check box if employee receives D Tips D Meals D Room D Health insurance	Check if these benefits are included in AWW D Tips D Meals D Room D Health insurance	NOi / Coder
Is the employer self-insured? D Yes x No	Were full wages paid for the DOT? D Yes D No	Are wages continued per C.R.S. 8-42-124? [1] D Yes D No	

Injmy/Illness date / / (See illustrations on reverse side)	Time employee began work ____ a.m. ____ p.m.	Injury time ____a.m. ____p.m. o unknown	Last day worked / /	Date employer notified / /	Date disability began / /	Date returned to work / /

Did injury cause death? D Yes D No	If so, date of death / /	Name, relationship, and address of closest dependent if injury caused death	Injury occurred because of Intoxication Safety violation Not applicable

Tell us the part of body that was affected	Tell us the nature of the injury/illness[2]
What was the employee doing just before the accident occurred?[3]	
Tell us how the injury occurred[4]	What object or substance directly harmed the employee? [5]

Did injury occur on premises? D Yes D No	Injury site address/ 9-digit zip code	Initial treatment (check one) D None D Emergency room D Minor on-site D Hospital >24 hrs D Clinic/hospital	Was the employee hospitalized overnight as an in-patient? D Yes D No

Names of witnesses	Name of employer representative notified
Name and address of treating doctor or other health care professional	Name and address of facility where treated

Completed by (name)	Title	Phone# ( )	Date completed / /

The following is to be completed by the insurer prior to filing with the Division of Workers' Compensation.

Name of insurance company Pinnacol	Address 7501 E Lowery Blvd Denver CO 80230-7006
Name of third party administrator (if applicable)	Address
Adjuster name	Adjuster phone #
Policy# 4244743 Carrier claim #	Date insurer received first report Block# Adj. Code