Together Achieving Team Excellence

COLDWATER • EAST TATE • INDEPENDENCE • STRAYHORN

Business office
574 Parkway Street
Coldwater, MS 38618
P (662)562-5861 F (662)622-7406
www.tatecountyschools.org

To: Tate County District Employees

From: Sandy Patton, Director of Finance

Date: December 1, 2023

RE: Worker Compensation Claim Forms

The attached documents must be completed when a Workers' Compensation claim is being filed.

The **MWCC-Workers' Compensation – First Report of Injury or Illness** and the **Choice of Physician** form must be e-mailed or faxed to the business office as soon after the incident occurs as possible. These documents are needed to start the claim process with our insurance carrier. These forms should be taken with the injured to the doctor's office because our insurance carrier's contact information and policy number is on the forms.

Within three days of the incident the following forms must be sent to the business office:

1. First Report of Injury
2. Choice of Physician form
3. Handwritten Statements from Witness Detailing the Accident

If you have any questions, please contact me at 662-562-5861 or by e-mail at spatton@tcsdms.org.

Thank you,

Sandy Patton

Sandy Patton

MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

TATE COUNTY SCHOOL DISTRICT
574 PARKWAY STREET
COLDWATER, MS 38618

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE # 662-562-5861

SIC CODE

EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)

Berkley Southeast Insurance Group
2760 47th Court
Meridian, MS 39305
1-855-802-5273 Fax 1-866-814-7532

POLICY PERIOD

10/1/2023 TO 9/30/2024

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN

POLICY/SELF-INSURED NUMBER
4419864-45

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX
☐ MALE (M)
☐ FEMALE (F)
☐ UNKNOWN (U)

MARITAL STATUS
☐ UNMARRIED/SINGLE/DIVORCED (U)
☐ MARRIED (M)
☐ SEPARATED (S)
☐ UNKNOWN (K)

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

OF DEPENDENTS

NCCI CLASS CODE

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:

#DAYS WORKED WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT
NO MEDICAL TREATMENT (0) ☐
MINOR: BY EMPLOYER (1) ☐
MINOR CLINIC/HOSP (2) ☐
EMERGENCY CARE (3) ☐
HOSPITALIZED > 24 HRS (4) ☐
FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) ☐

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

SEE BACK FOR INSTRUCTIONS

Berkley Southeast Insurance Group

Trusted Choice

Dear Valued Policyholder

Subject: Mississippi Workers' Compensation Claim Service

Thank you for entrusting Berkley Southeast Insurance Group with your insurance needs. Our goal is to provide quality insurance products and excellent claim service that exceeds your expectations.

We are providing you with access to your Workers' Compensation Claim Service Kit to assist you with reporting your workers' compensation claims, as well as answer some general questions. You will also be able to access other states that we handle from this link. **Please set this link as a favorite on your tool bar so that you have easy access to us when your need to call on us.** The following tools are available via the attached link (http://berkleysig.com/WC-kits-ALLSTATES.php):

- The Mississippi state site can be found at http://www.mwcc.state.ms.us/.
- **Workers' Compensation Notice of Coverage Posting**. This form should be completed and posted. English: (https://mwcc.ms.gov/pdf/noticeofcoverageform.pdf) Spanish: https://mwcc.ms.gov/pdf/noticeofcoverageformsp.pdf is to be posted pursuant to Mississippi General Rule 8 **Courtesy Copy Attached**
- **Claim Reporting Procedures:** Instructions for reporting and handling workers' compensation claims. **Courtesy Copy Attached**
- **Claim Service Team:** Contacts to assist you with claims and claims reporting.
- **Workers' Compensation First Report of Injury:** This is the state form for reporting occupational injury/illness claims. Additional copies of this form are available, without cost, from the Mississippi Workers' Compensation Commission or by accessing their website at https://mwcc.ms.gov/pdf/1streport.pdf
- **Wage Statement:** If an injured worker is disabled and out of work for four or more days, he/she may be eligible for compensation. The average weekly wage is based on the prior 52-week wage history which will be needed by the adjuster in order to properly calculate benefits. You will find a copy of a form that you may use on our website.
- **Pharmacy First Fill Form:** Instructions for getting your employee's initial prescription filled at no cost to him/her is included.
- **Guide to Cost Containment and Modified Return to Work:** Guide to steps you can take to protect your assets and control your exposures.
- **Fraud Posters:** Multiple fraud posters in English and Spanish versions.

Remember, the sooner you report an injury, the sooner we can help.

Upon review of this information, or at any time in the future that you have questions or concerns, please do not hesitate to give me a call.

We look forward to being of service to you.

Tracel Jackson (678-533-3476)
Workers' Compensation Claim Director

NOTICE OF PHYSICIAN CHOICE AND MEDICAL AUTHORIZATION

Claimant's Name _____

Claimant's Social Security Number XXX-XX-_____

Employer's Name _____

Date of Injury _____

MWCC No. _____

I am claiming to have sustained an injury involving my _____

I am ____ am not ____ claiming that my medical condition is work-related.

If work-related:

I understand that under the Mississippi Workers' Compensation Law, I have the right to choose one physician to render treatment to me. I can either accept the physician to whom I am sent by my employer or choose someone else on my own.

I also understand that any referral to any other doctor must be made by my one chosen physician.

I also understand that my employer (or Workers' Compensation Carrier) must approve any physician change, and that if I change doctors without their authorization, I will be responsible for the medical expenses for the unauthorized treatment.

With that understanding, I state as follows:

____ I accept as my choice of physician my employer's tender of treatment by Dr. _____

____ I elect to choose my own physician to render treatment and that choice is Dr. _____

I also hereby authorize any doctor, physician, psychologist, hospital, or other provider of medical and related care to release unto and/or discuss with my employer, their agents, employees, workers' compensation insurance carrier, third party administrator, or attorney, all medical information including reports, psychological test results, opinions, records, x-rays, x-ray reports, laboratory reports, nurse's notes, physicians' orders, and any and all other documents relating to any examination or treatment of myself.

I hereby agree that a copy of this authorization form shall have the same force and effect as the original thereof and further agree that this authorization shall remain valid so long as the claim against my above-named employer is pending.

_____

Claimant's signature

Date:_____

Witnessed by:

_____

_____

Berkley Southeast Insurance Group
A Berkley Company

Smi+hRx
Pharmacy Benefits Simplified

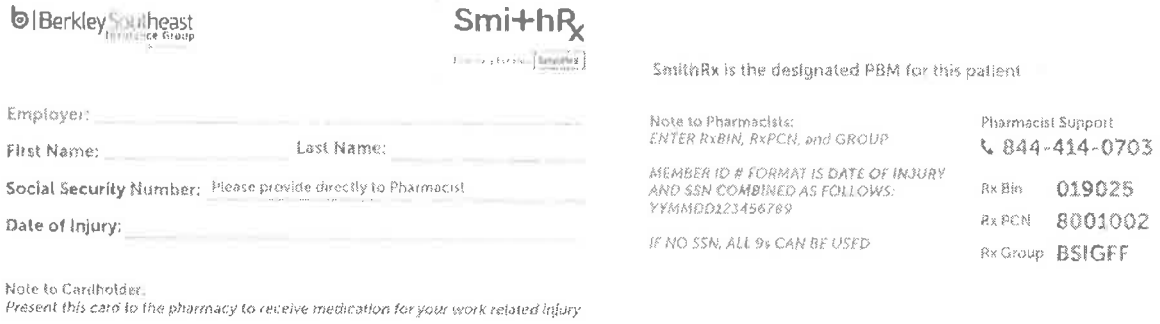
Welcome to SmithRx. Your employer has chosen SmithRx to provide pharmacy benefits for their injured workers. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy.

Injured Employee:

- If you need a prescription filled for a work-related injury or illness, go to an in-network pharmacy. Provide this temporary card to the pharmacist. The pharmacist will fill your prescription at no cost to you.
- This card is valid for one-time use. You have 7 days from your date of injury to utilize this card.
- If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Please use that card for future work-related injury or illness prescriptions.
- Most pharmacies, including all major chains, are included in this network. To find or inquire about a network pharmacy, call (844) 414-0701.

Questions?

- If you have any questions, please call (844) 414-0701 (also located on the back of your ID card).


Berkley Southeast Insurance Group

Smi+hRx

SmithRx is the designated PBM for this patient

Employer: _____

First Name: _____ Last Name: _____

Social Security Number: Please provide directly to Pharmacist

Date of Injury: _____

Note to Cardholder:
Present this card to the pharmacy to receive medication for your work related injury

Note to Pharmacists:
ENTER RxBIN, RxPCN, and GROUP

MEMBER ID # FORMAT IS DATE OF INJURY AND SSN COMBINED AS FOLLOWS: YYMMDD123456789

IF NO SSN, ALL 9s CAN BE USED

Pharmacist Support
844-414-0703

Rx Bin 019025
Rx PCN 8001002
Rx Group BSIGFF

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

Berkley Southeast Insurance Group
A Berkley Company

SmithRx
Pharmacy Benefits. Simplified.

Bienvenido a SmithRx.

Su empleador nos ha elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales. Más adelante incluiremos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local.

Empleado lesionado:

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

Esta tarjeta es válida para un solo uso. Tiene 7 días a partir de la fecha de la lesión para utilizar esta tarjeta.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Puede utilizar esta tarjeta para futuras recetas médicas por lesiones o enfermedades relacionadas con el trabajo.

La mayoría de farmacias, incluyendo todas las grandes cadenas de farmacias, forman parte de nuestra red. Para encontrar una farmacia en nuestra red, llame al **(844) 414-0701**.

¿Tiene Preguntas?

Si tiene alguna pregunta, llame al **(844) 414-0701** (también se encuentra en la parte posterior de su tarjeta de identificación).

Berkley Southeast Insurance Group

SmithRx
Pharmacy Benefits. Simplified.

Employer: _____

First Name: _____ Last Name: _____

Social Security Number: Please provide directly to Pharmacist

Date of Injury: _____

Note to Cardholder:
Present this card to the pharmacy to receive medication for your work related injury

SmithRx is the designated PBM for this patient

Note to Pharmacists:
ENTER RxBIN, RxPCN, and GROUP

MEMBER ID # FORMAT IS DATE OF INJURY AND SSN COMBINED AS FOLLOWS: YYMMDD123456789

IF NO SSN, ALL 9s CAN BE USED

Pharmacist Support
844-414-0703

Rx bin 019025
Rx PCN 8001002
Rx Group BSIGFF

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

National Chain Pharmacy Listing

Below is a list of national pharmacy chains that participate in the **SmithRx** pharmacy network. Many additional independent pharmacies across the United States also participate in our network.

This list is subject to change. To determine if a pharmacy is currently in our network, please call SmithRx at (844) 414-0701.

Albertsons
Bartell Drugs
Bashas' United Drug
Baylor Scott and White Pharmacy
Bi-Mart Pharmacy
Brookshire Pharmacy
City Market
Costco Pharmacy
Cub Pharmacy
CVS Pharmacy
Dierberg Pharmacy
Dillon Pharmacy
Duane Reade
Fairview Pharmacy
Food City Pharmacy
Food Lion Pharmacy
Fred Meyer Pharmacy
Fred's Pharmacy
Fry's Food and Drug
Giant Eagle Pharmacy
Giant Pharmacy
Hannaford Food and Drug
Harps Pharmacy
Harveys Supermarket
H-E-B Grocery
Henry Ford Medical Center Pharmacy
Homeland Pharmacy
Hy-Vee
Ingles Markets Pharmacy
King Soopers Pharmacy
Kinney Drugs
Knight Drugs
Kroger Pharmacy
Maxor Pharmacy
Medicap Pharmacy
Medicine Shoppe Pharmacy
Navarro Discount Pharmacy
Pick N Save Pharmacy
Pillpack
Publix Super Market
Quality Food Center
Ralphs Pharmacy
Recept Pharmacy
Rite Aid Pharmacy
Safeway Pharmacy
Save Mart
Sav-Mor
Schnuck Market
Shoprite Pharmacy
Smith's Pharmacy
Stop & Shop Pharmacy
Target
Thrifty Drug Store
Tom Thumb Pharmacy
U Save It
Vons Pharmacy
Walgreens
Walmart
Wegman Food Market
Winn Dixie