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 WC Claim*** *(Page 2)* **Optum First Fill®** ***Card*** *(Page 3 & 4) and contact Human Resources immediately*

- ❑ You must ensure a **First report of Injury** is completed with or with or without the employee's assistance! Go to **this link** at **www.tasbrmf.org** and complete **First Report of Injury** and file no later than the next business day. You do not need to log in to complete the First Report of Injury. (Complete with as much information as you have, see instructions on pages 9-17)

- ❑ Have the employee sign **Acknowledgment of Medical Alliance** (Pages 5 & 6)

- ❑ If Employee feels he/she may seek medical treatment complete and give the **Verification of Employment for Reported WC Claim**(Page 2) and **Optum First Fill® Card**(Page 3 & 4)

- ❑ 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 7 & 8)

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

Rosario Lopez, Benefits Analyst
Phone: 409.989.5252
Fax: 409.989.6175
Email: rosario.lopez@paisd.org

Please refer injured employee directly to Human Resources for any further questions or issues regarding any workers' compensation injury. Alert Rosario Lopez 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.

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

Please take this form to the doctor for your first medical examination.

Employee Name_____ Date of Injury _____

Date of Birth_____ Social Security _____

Reported Work Related Injury or Illness:

_____

_____

Port Arthur ISD (member organization) 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 pswca.org.

Please submit all claim and medical billing information to:

TASB
P.O. Box 2983
Clinton, IA 52733-2983
Phone: 800.732.0153
Fax: 732.212.7009

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

Pre-Authorization
Phone: 800.482.7276, x9907
Fax: 888.777.8272

Issuing Signature_____ Title _____

Phone Number_____ Date _____

Providers please submit Work Status Reports and all Job Description inquiries to:

Contact Name, Title Rosario Lopez, Benefits Analyst

Phone 409.989.5252

Fax 409.989.6175

Email rosario.lopez@paisd.org

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

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

Port Arthur ISD — 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

OPTUM®

PO Box 152539
Tampa, FL 33684-2539

TASB RISK FUND

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

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

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias y todas las grandes cadenas de farmacias forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

TASB Risk Mgmt. Fund — PORTADORA
Port Arthur ISD — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Por favor provea directamente al farmacéutico
NUMERO DE SEGURO SOCIAL — FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite 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	TASBF		

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

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1813-37

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: Port Arthur ISD
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.

To be completed by the employer only

Please indicate whether this is the:
- ☐ Initial Employee Notification
- ☐ Injury Notification (Date of Injury:_____/_____/_____)

Do not return this form to the TASB Risk Management Fund unless requested.

Reconocimento Del Empleado Para El Programa De Contratar Directamente Con Medicos

He recibido la informacion que explica como obtener tratamientos medicos si me lastimo en el trabajo. Si estoy lastimado en el trabajo y vivo en un área de servicio descrita en esta información, entiendo que:

1. Tengo que escojer un doctor de la lista de la Alliance (PSWCA), que son señalados para tratar.
2. Debo ir a este doctor para todo el tratamiento médico para mi lesión. Si necisito un especialista, el doctor que me trata me referirá. Si necesito tratamientos de emergencia, yo entiendo que puedo ir a cualquier profesional médico licenciado dentro de los Estados Unidos.
3. Si el doctor me refiere a un especialista, yo entiendo que necesito verificar que el doctor sea un miembro del la Alliance.
4. TASB le pagara al doctor escojido y a doctores tambien que son partidos de PSWCA.
5. Puedo ser responsable de la cuenta si recibo tratamento medico de doctores que no son miembros de la Alliance y sin la aprobacion anterior de TASB.
6. Reportando un reclamo de lastimaduara falsa o fraudulenta es un crimen que puede resultar en multas y o al encarcelamiento.
7. Si deseo cambiar doctores despues de mi primera opción, puedo hacerlo dentro 60 dias de comensar mi tratamieto. Puedo solamente escojer de la lista de doctores que estan en el Alliance. La tercer opción necesita probacion de mi ajustador antes de cabiar doctor.

_____ _____/_____/_____
Firma (Signature) Fecha (Date)

_____
Nombre en imprenta (Printed Name)

_____
Direccion de domicilio incluindo cuidad, estado y zip (Address)

Nombre de empleo (Name of Employer): Port Arthur ISD
Nombre del programa de contratar doctores directament (Name of Direct Contracting Program): Political Subdivision Workers' Compensation Alliance (the Alliance)

El servicio de contratar doctores directamente en las areas de servicio, son subjetivos a cambiar. Para localizar un doctor de tratamiento en su area, visite al Internet en: **www.pswca.org** o llame a su ajustador al numero: 800.482.7276.

To be completed by the employer only

Please indicate whether this is the:

- ☐ Initial Employee Notification
- ☐ Injury Notification (Date of Injury:_____/_____/_____)

Do not return this form to the TASB Risk Management Fund unless requested.

FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION (NO OFFSET—ENGLISH VERSION)

Name _____ **Employee number** _____

Position_____ **Department/Campus** _____

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.

_____ _____

District authorized signature Date

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 -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 Port Arthur 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 receive only 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

For Claims Reporting Purposes Only:	
For all employees: Amount of leave paid to employee: $ ____.__ Daily rate: $ _____ Period of payment: from___/___/___ through___/___/___ for ____ days **or** ____ weeks	*For hourly employees only:* Hourly rate: $____.___ Number of hours paid: _____

FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION (NO OFFSET—SPANISH VERSION)

Nombre _____ **Número de empleado** _____

Posición _____ **Departamento/campus** _____

Este empleado está ausente de su trabajo debido a una enfermedad o lesión relacionada con el trabajo que comenzó en *(fecha de la primera ausencia que se atribuye a enfermedad o lesión)*. Si es elegible, el seguro de compensación de los trabajadores puede comenzar a pagar un porcentaje de los salarios actuales del empleado en el octavo día de ausencia del trabajo, en caso de que se requiera una ausencia prolongada.

_____ _____

Firma autorizada de distrito Fecha

Elección del empleado:

Estoy ausenté del trabajo debido a una enfermedad o lesión relacionada con el trabajo. Comprendo que no soy elegible para los beneficios de ingreso semanales de compensación para trabajadores hasta que mi ausencia exceda los siete días calendario. También comprendo que el distrito continuará pagando su aporte hacia el costo de mi cobertura de seguros médicos (si es aplicable) siempre y cuando estoy en licencia **con goce de sueldo** y/o licencia familiar o médica (FMLA). Asimismo, comprendo que seré responsable de pagar todas las primas de seguros médicos si estoy en licencia **sin goce de sueldo** que no sea una licencia FMLA. Elijo la siguiente opción:

- ❑ Elijo utilizar solamente _____ días de licencia disponible con goce de sueldo en esta oportunidad.
- ❑ Elijo utilizar todas las licencias con goce de sueldo disponibles. Comprendo que no recibiré los beneficios de ingresos semanales de compensación de los trabajadores hasta que haya acabado toda mi licencia con goce de sueldo o hasta en que la licencia con goce de sueldo no es equivalente a mi sueldo previo a la enfermedad o a la lesión.
- ❑ Elijo **no** utilizar la licencia con goce de sueldo disponible en esta oportunidad. Comprendo que no recibiré pagos de salario regulares de Port Arthur ISD mientras reciba los beneficios de ingreso semanales conforme a la compensación de los trabajadores. No se deducirá la licencia con goce de sueldo disponible de mi saldo de licencia. Asimismo, comprendo que, al seleccionar esta opción, recibiré solamente los beneficios de salario de compensación de los trabajadores para las ausencias que deriven de mi enfermedad o lesión relacionada con el trabajo, a menos y hasta que comunique al distrito un cambio en mi decisión.

_____ _____

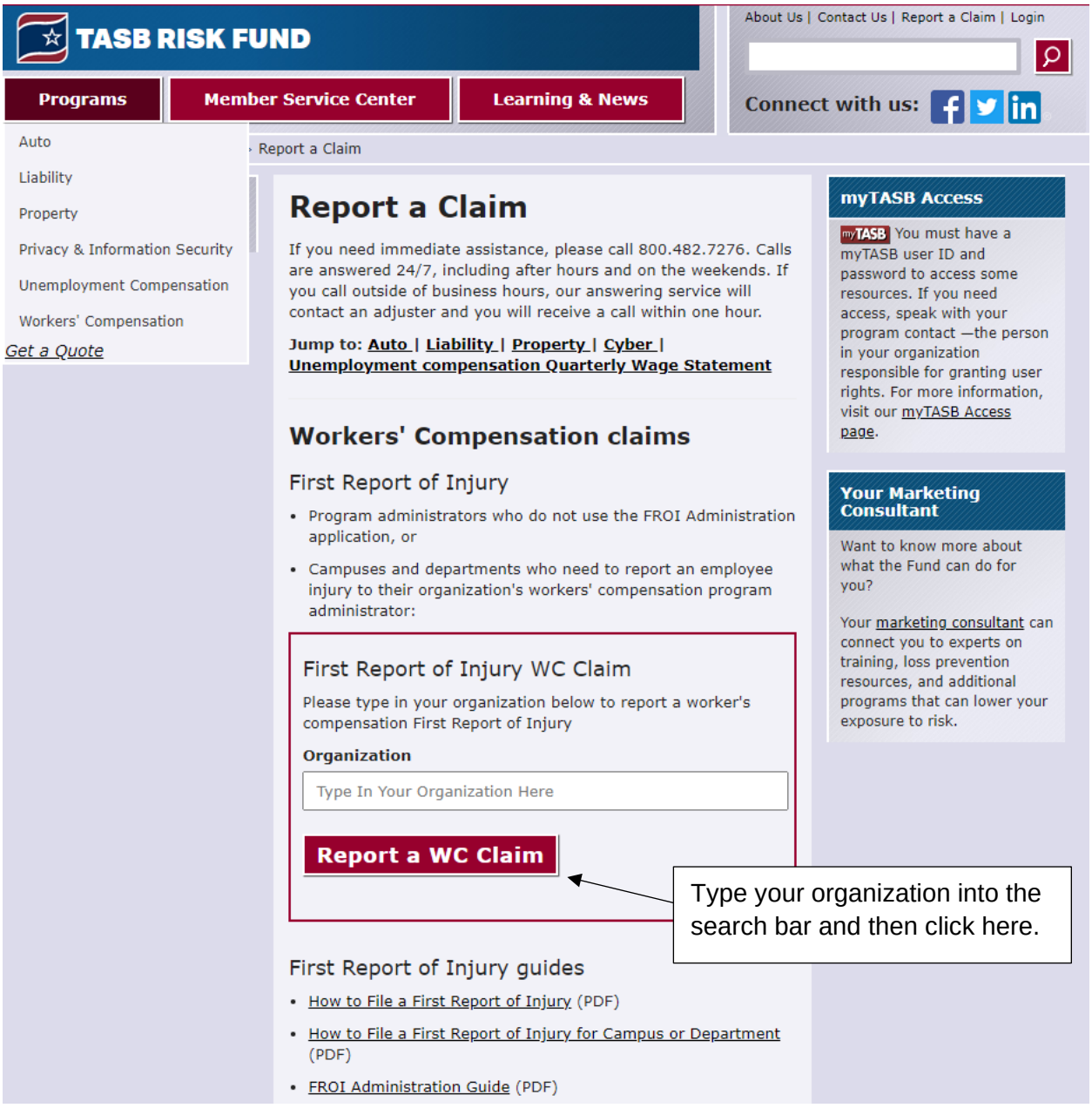
Firma del empleado Fecha

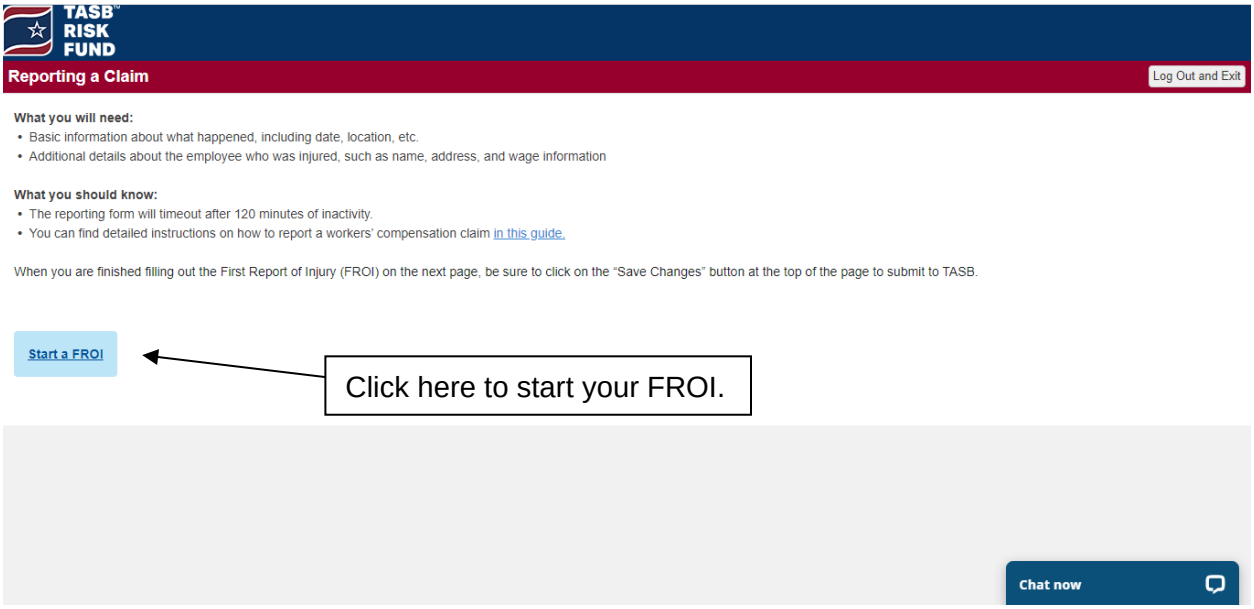
For Claims Reporting Purposes Only:	
For all employees: Amount of leave paid to employee: $ ____.__ Daily rate: $ _____ Period of payment: from___/___/___ through___/___/___ for ____ days **or** ____ weeks	*For hourly employees only:* Hourly rate: $____.___ Number of hours paid: _____

How to File a First Report of Injury

Campus or Department Instructions

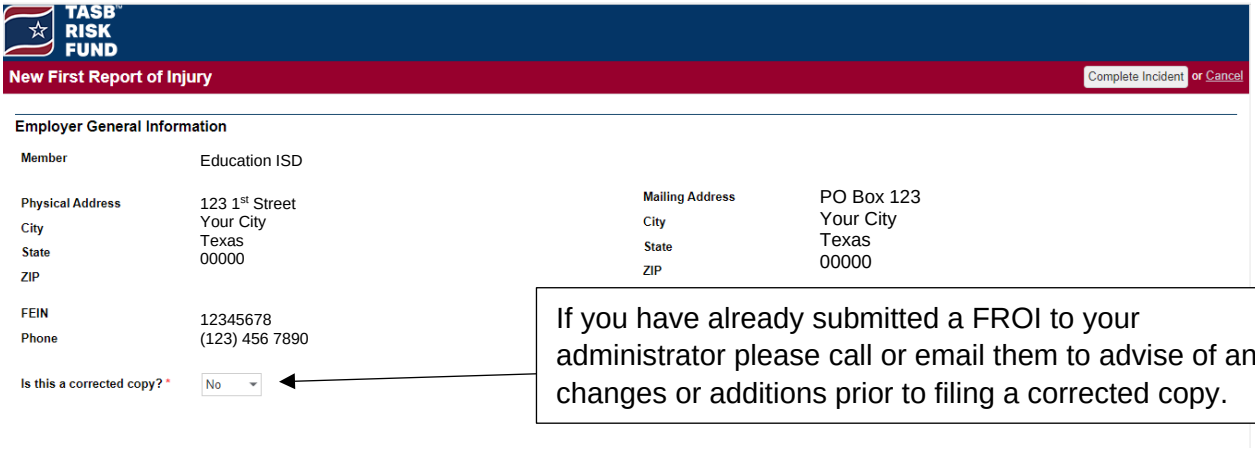
Start here: tasbrmf.org/claims



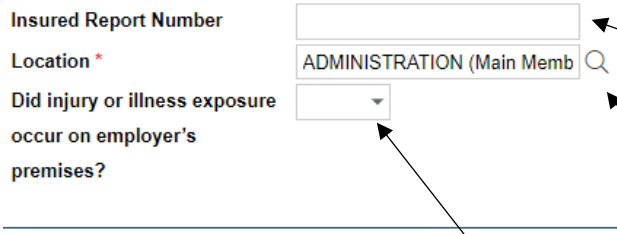


Important: Please note that all items marked with a red asterisk (*) are mandatory. If you are unsure of the correct information, please use the applicable placeholders listed in this guide. Placeholders are outlined in red.

Any placeholders or incorrect information will be corrected by your administrator upon submission.



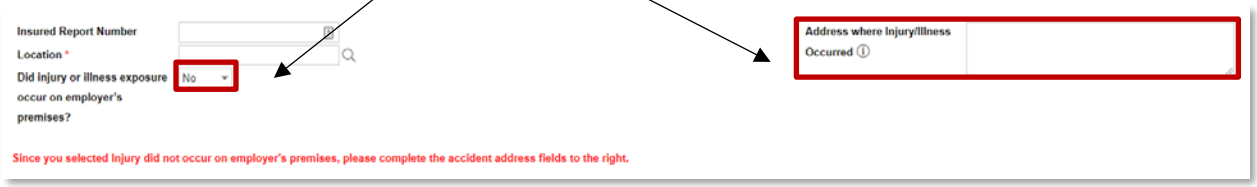
If you have already submitted a FROI to your administrator please call or email them to advise of any changes or additions prior to filing a corrected copy.

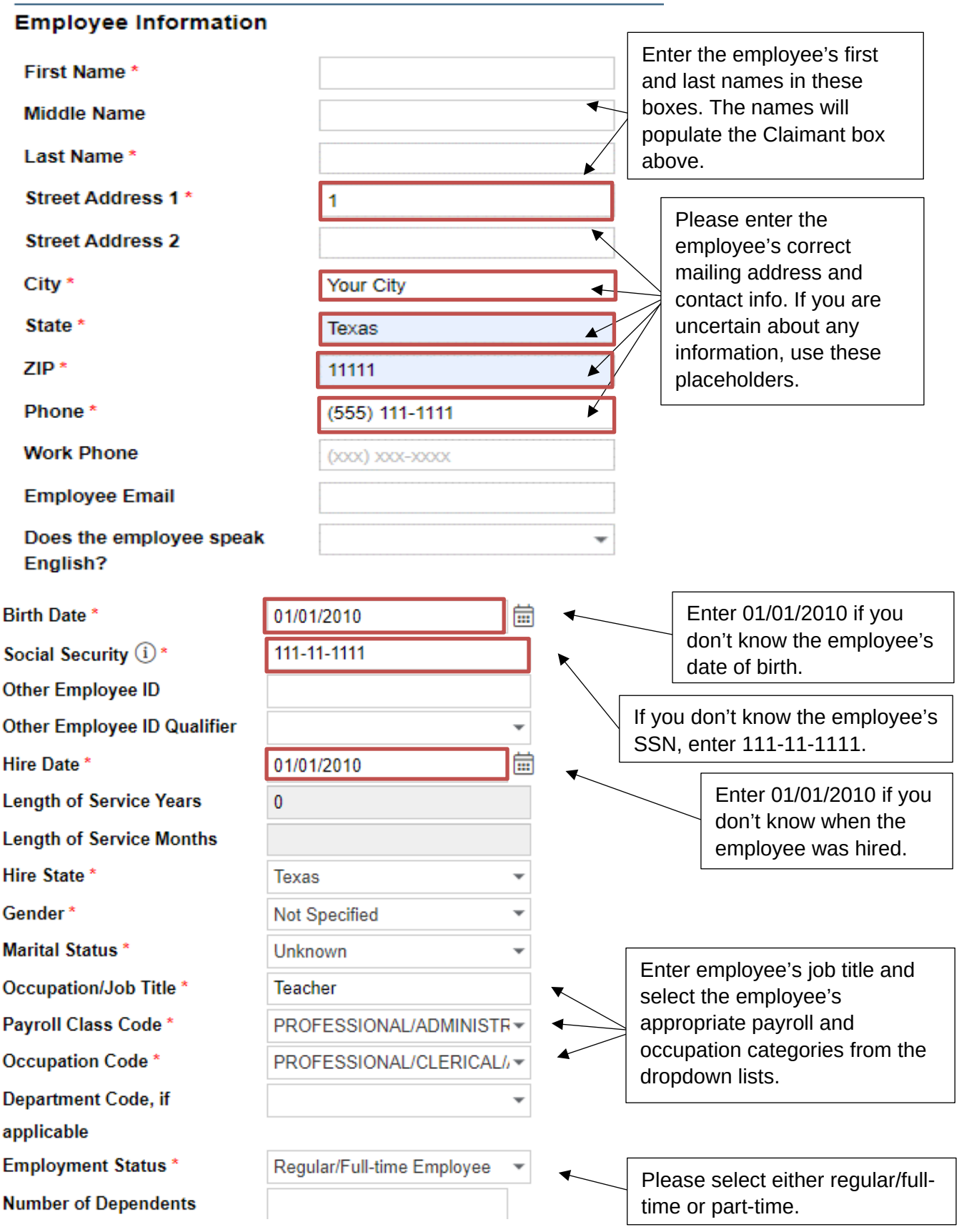


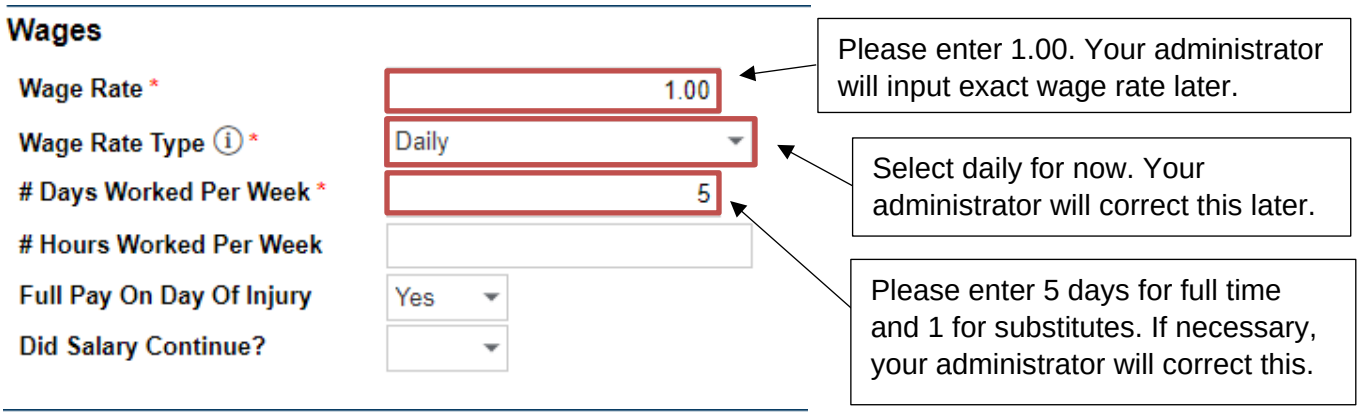
If your organization uses employee numbers, you may enter the injured employee's number here. If not, leave this blank.

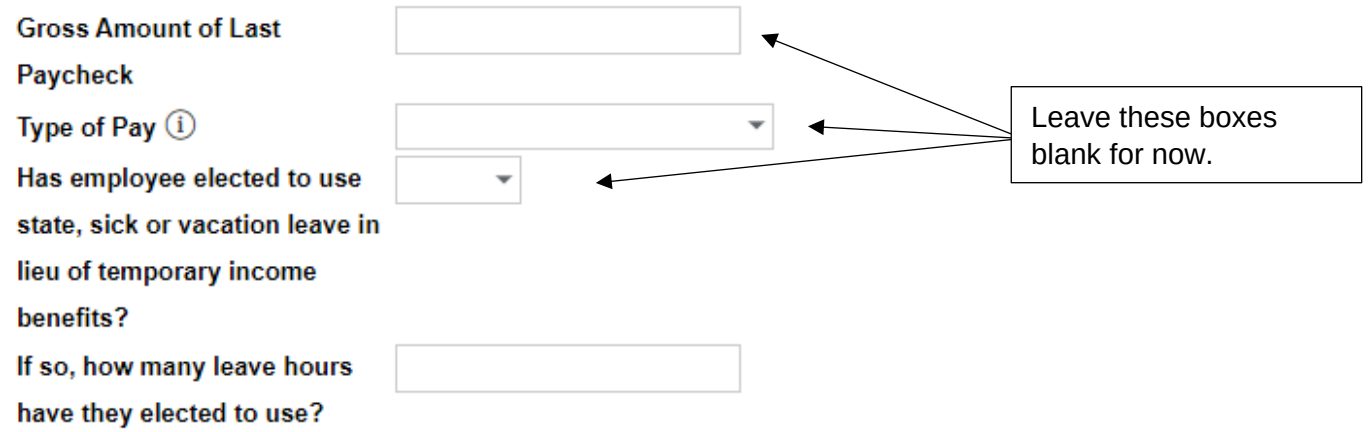
Click on the magnifying glass to select the applicable location from the list.

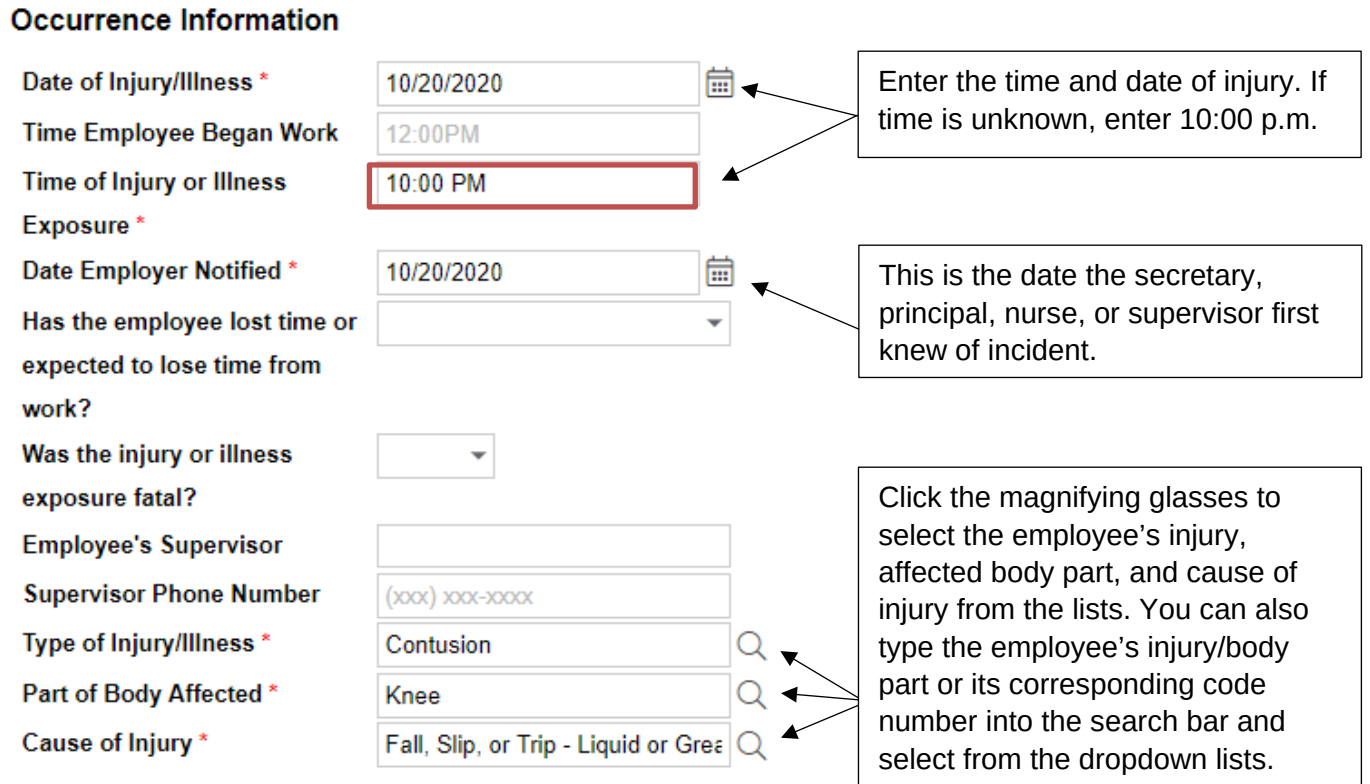
If the injury occurred off campus, select "No" and enter the address of the injury in a box that will appear to the right.

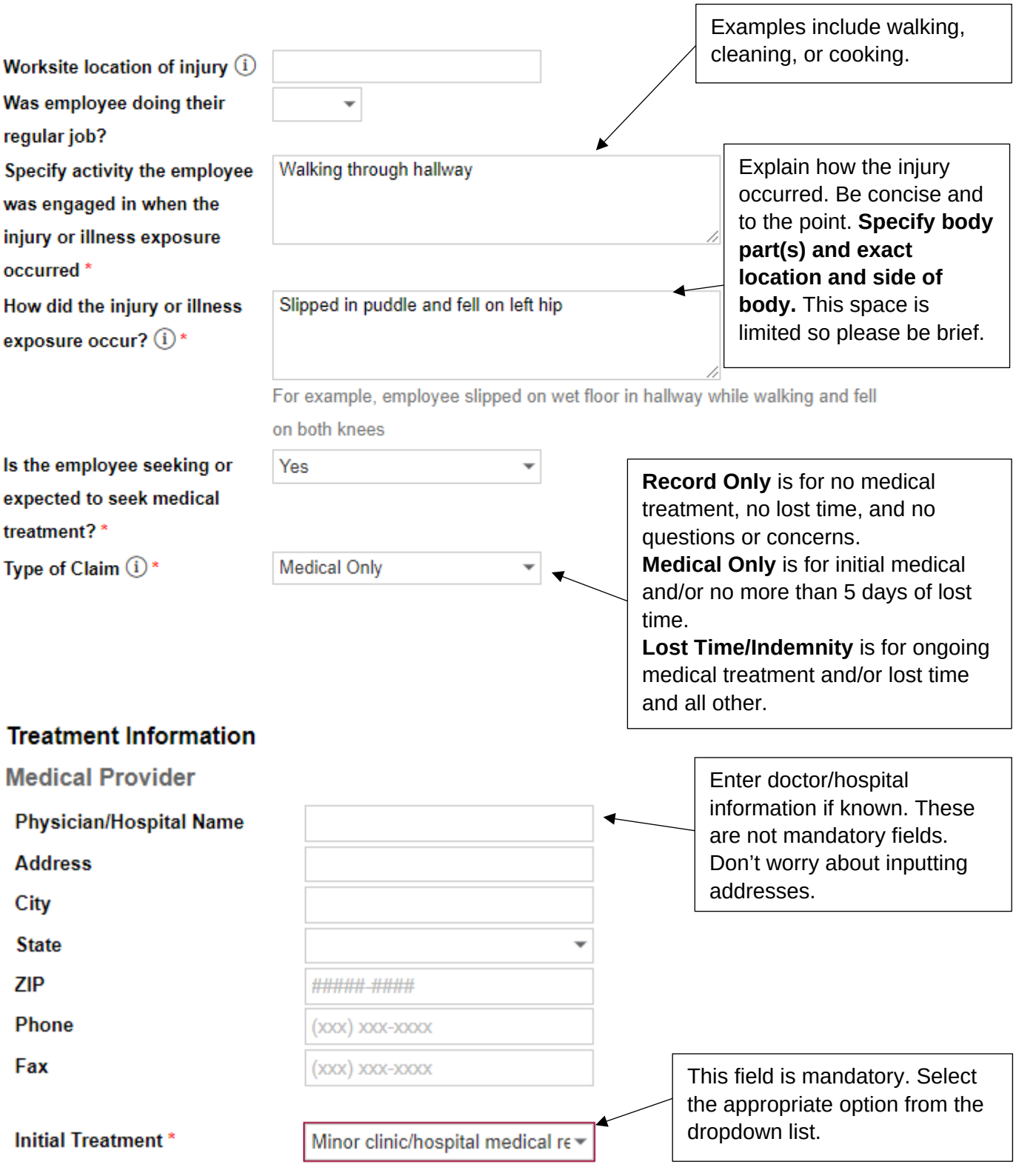


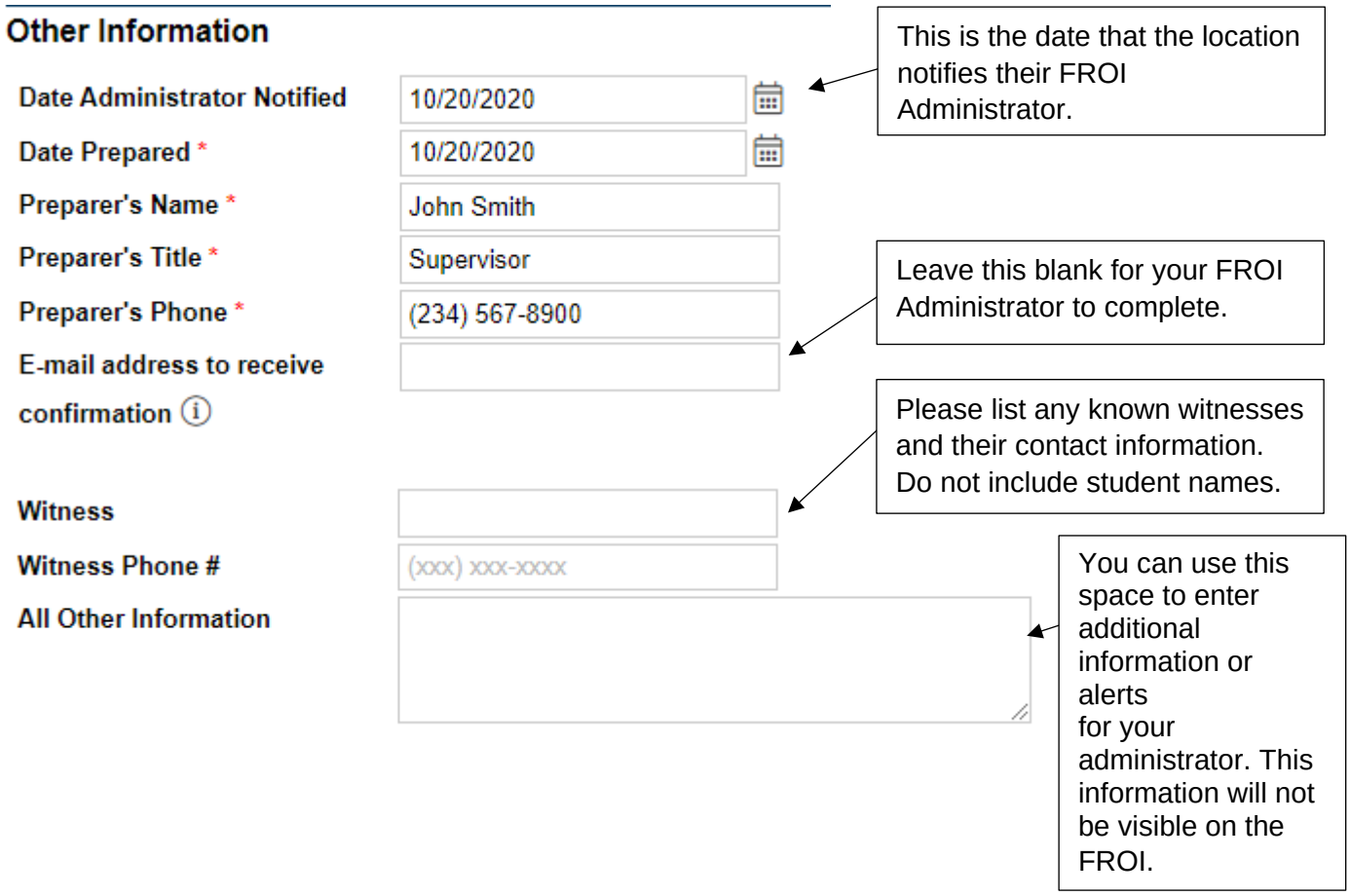


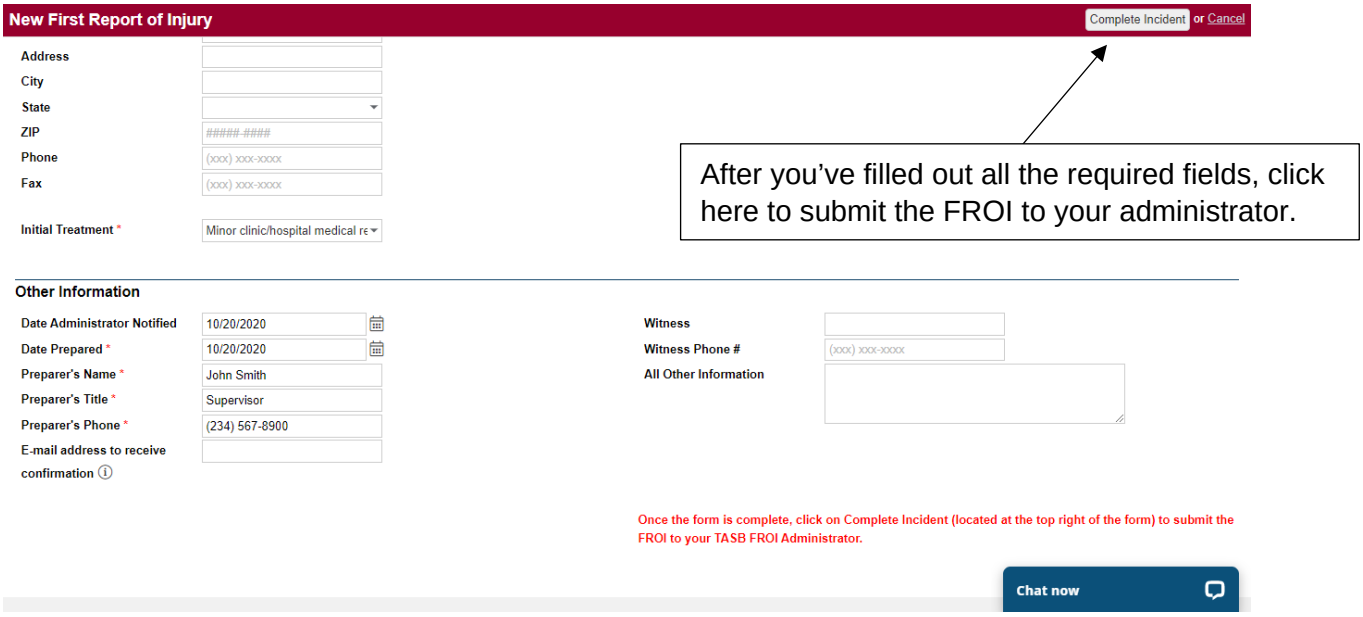


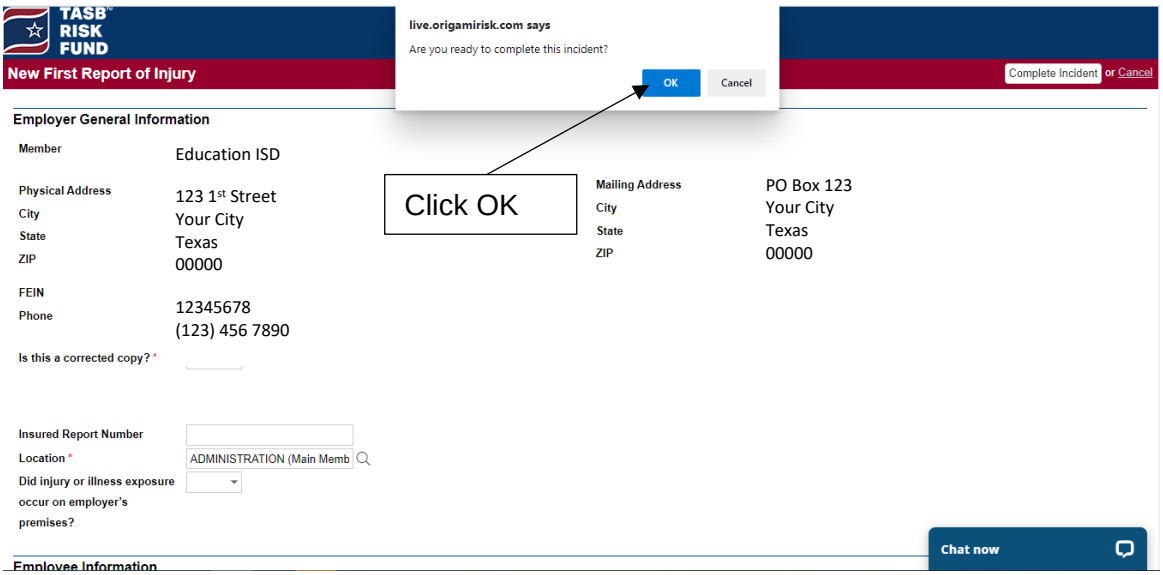


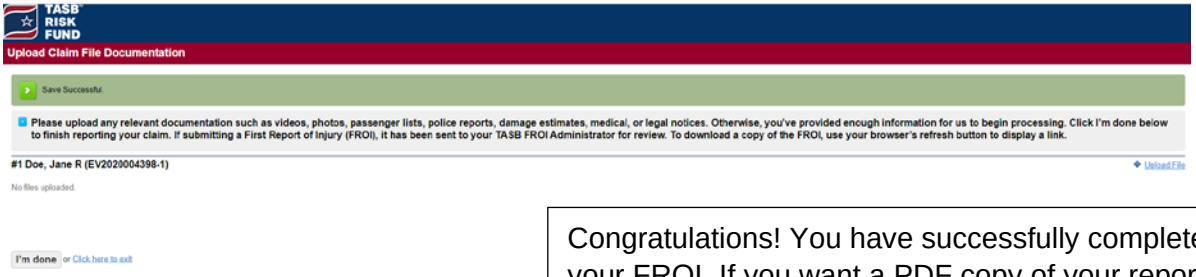






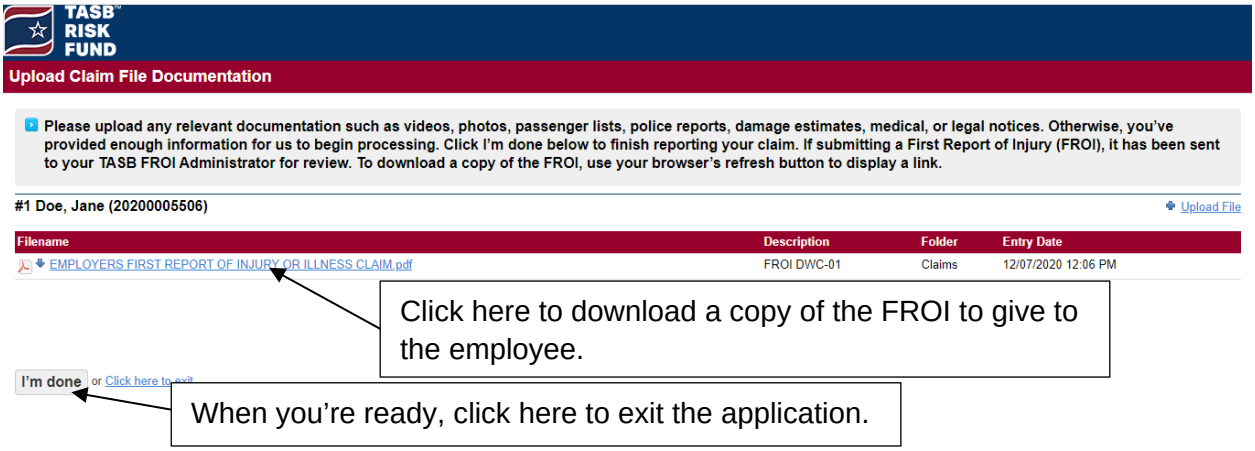






Congratulations! You have successfully completed your FROI. If you want a PDF copy of your report, refresh your browser and a link will appear.

How to Refresh your browser:
Chrome: Hold down Ctrl and press F5
Chrome & Mac: Hold down Command, Shift and click the 'R"key
Firefox & Windowns: Hold down Ctrl and press F5
Firefox & Mac: Hold down Command, Shift and the 'R" key
Safari: Hold down the option and command key then press the 'E"key
Internet Explorer: Hold the Control key, press the F5 key.



If you have questions contact your FROI Administrator or inquiry@tasb.org or 800.482.7276