Beaumont Independent School District
Insurance Department

Reporting Employee Injuries

What to do when there is an injury on the job.

The campus nurse has been designated as the point of contact to report all work-related employee illnesses/injuries.

This packet contains instructions for nurses to follow to report on-the-jog injuries

> **For TRUE Emergencies, please direct employees to the nearest Hospital Emergency Room**
>
> ***NOTE: Urgent Care centers are NOT considered Emergenct Rooms - send TRUE emergencies to the Hospital ER.**

> **For NON-EMERGENCIES, employees must seek treatment from an Alliance Provider (list attached)**

> **If an injured employee is TRANSPORTED BY AMBULANCE or EMS, promptly notify the BISD Insurance Office at 617-5028.**

What to do:

Have Injured Employee complete and sign the following documents:

1. **Incident Report - completed/signed the day of the incident**
2. **Employee Acknowledgment of Medical Alliance**
3. **Medical Authorization Form**
4. **Send above 3 completed/signed forms and checklist to BISD Insurance office Fax to 617-5180 or email to canders@bmtisd.com**
5. **Notify BISD Insurance Office when an injuried employee is missing time**
6. **Forward a Doctor's Release when an injured employee returns to work**

Distribute to Employee:

1. **Copy of completed/signed Incident Report**
2. **Copy of signed Acknowledgment of Medical Alliance Form**
3. **Copy of Political Subdivision Workers Compensation Alliance provider listing**
4. **Helios First Fill - Prescription Program Form**

Fax or email the original Incident Report ASAP to the BISD Insurance Office.

Insurance Department: Fax: 617-5180 **Phone: 617-5028 or 617-5029**

Beaumont Independent School District

Incident Report

➢ An *Administrator, Supervisor* or *Nurse* must report an on-the-job injury to the ***BISD Insurance office*** **within 24 hours.**

Employee Name: _____ _____
Last First

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Home Phone:** _____-_____-_____ **Cell:** _____-_____-_____

Marital Status: ☐S ☐M ☐D ☐W **Name of spouse:** _____

Date of Birth: ___/___/___ **Gender:** ☐F ☐M **Last 4 of Social:** _____

Date of Injury: ___/___/___ **Time of Injury:** _____ a.m. _____ p.m.

Occupation: _____ **Hire Date:** ___/___/___ **Wages/hour or day: $** _____

Are you able to work? ☐Yes ☐No **First day unable to work:** ___/___/___

Supervisor : _____ **When did your Supv. first know of injury:** ___/___/___

Work Location/Campus: _____ **Supervisor phone number:** _____

Campus where injury Occurred: _____

Location injury occurred (stairs, classroom, parking lot, etc.): _____

Describe fully how incident occurred and state what you were doing when injured:

_____

_____

Describe part(s) of body affected: _____

Back Injuries: MUST SPECIFY: **UPPER – MIDDLE – LOWER** (circle)

All other injuries: MUST SPECIFY: **RIGHT or LEFT** (circle)

Date this form was completed: _____

_____
Signature of Employee

_____
Signature of Nurse

☐ **Reporting only (not seeking treatment at this time)**

Campus Nurse Printed Name: _____

☐ **Seeking treatment at:** _____

BISD Insurance Office **Phone: 617-5028 / 617-5029** **Fax: 617-5180**

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:

_____

_____

_____(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

Phone

Fax

Email

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

EMPLOYEE ACKNOWLEDGMENT 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: BEAUMONT INDEPENDENT SCHOOL DISTRICT

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 www.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.

TASB RISK
MANAGEMENT FUND

12007ResearchBlvd.•Austin,Texas 78759-2439•P.O.Box2010•Austin,Texas 78768-2010
Tel800.482.7276•Fax800.580.6720•tasbrmf.org

AdministeredbytheTexasAssociationofSchoolBoards,Inc

November 14, 2016

Dear :

At the bottom of this document, you will find a Medical Authorization Release. This release is necessary for us to properly evaluate your workers' compensation claim.

Please read and sign this form, which authorizes the TASB Risk Management Fund to obtain appropriate medical records necessary to complete our investigation. Your prompt return of the authorization form below will help expedite our investigation. After you have signed the authorization, return it to our office in the enclosed envelope.

If you have any questions, call me at 800-482-7276, extension . Our office hours are from 8 a.m. to 5 p.m., Monday through Friday.

Sincerely,

Claims Representative

MEDICAL AUTHORIZATION

You are hereby authorized to provide the TASB Risk Management Fund and its representatives any and all medical information relevant to my workers' compensation injury claim. This authorization also includes permission to copy or view all of the hospital notes, records and information, including but not limited to laboratory tests and x-rays, histories, examinations, tests, treatment, consultations and opinions and any and all other information relevant to this claim. Medical information relevant to this claim includes past history of complaints or treatment of any conditions similar to that presented in the claim or other conditions related to the same body part.

To address privacy concerns, HIPAA Rule 45CFR 512(1) specifically authorizes provider disclosure of protected health information without an individual's authorization to the extent necessary to comply with workers' compensation laws.

A copy of this form shall have the same effect as the original.

_____ _____

Signature Date

Name:
Social Security Number:
Date of Injury:

OPTUM

TASB RISK MANAGEMENT FUND

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for TASB Risk Management Fund. 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, including Walgreens, our preferred provider, 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

TASB RISK MANAGEMENT FUND

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

TASB Risk Management Fund — CARRIER/TPA

Beaumont 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. This card is not valid for compound medications.

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®

OPTUM

TASB RISK MANAGEMENT FUND

Optum
PO Box 152539
Tampa, FL 33684-2539

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 TASB Risk Management Fund. 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, incluyendo Walgreens, nuestro proveedor preferido, 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

TASB RISK MANAGEMENT FUND

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

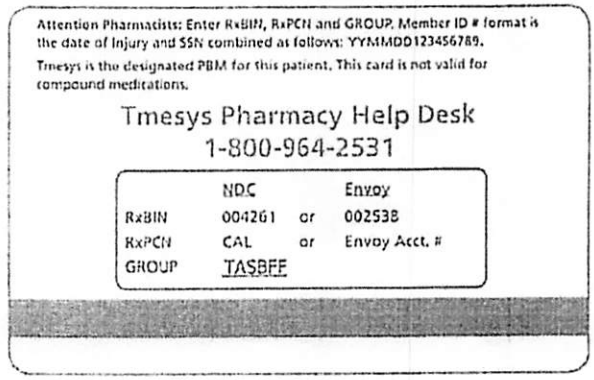
TASB Risk Management Fund	Beaumont ISD
PORTADORA	EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist

NUMERO DE SEGURO SOCIAL — FECHA DE ALA LESION (AA/MM/DD)

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. This card is not valid for compound meditations.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	TASBFF		

NOTA: Esta tarjeta First Fill solo es valida 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®

IMP14-1614-167

EMPLOYEE INJURY AND TREATMENT FORM

Name: _____ Campus: _____

Position: _____ Supervisor: _____

Current Mailing Adress:

Home Phone: ( ) - _____ Cell Phone: ( ) - _____

Email: _____

Date of Injury: _____ Time of Injury: _____ Date Reported: _____

Part of Body Injured: _____

Location injury occurred (include specific location on campus or jobsite): _____

Activity engaged in when injury occurred: _____

Description of how injury occurred: _____

Witnesses: _____

Treating physician: _____ Expected return to work date: _____

Filing for assault leave means you must leave the campus and seek medical treatment for your injury. You cannot return to duty until you are released by your treating doctor. Do you wish to file for assault leave? YES or NO (circle)

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Please email this form to the Benefits Department immediately at
canders@bmtisd.com

If you have any questions, please call: (409)617-5028

BEAUMONT INDEPENDENT SCHOOL DISTRICT
BEAUMONT, TEXAS

ACTION REQUIRED:
Complete, sign and return this form to the Insurance Dept.!

Workers' Compensation Choice Form

Name _____ **Employee #** _____ **Date** _____

Position _____ **Location** _____

DOI _____ **Date Lost Time Began** _____

If a BISD employee is unable to work due to an on-the-job injury, Workers' Compensation begins to pay a portion of the employee's wages on the 8th day after the injury. ***The employee must choose one of the options listed below. If no response is received, the third option will be in effect.***

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 7 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.** A full leave day will be charged for each day of absence. I understand that I will not receive workers' compensation weekly income benefits until after those leave days are complete.

- ☐ **I choose to use paid leave until all leave is exhausted (sick, personal & vacation).** A full leave day will be charged for each day of absence. I understand that I will not receive workers' compensation weekly income benefits until I have exhausted all of my paid leave. Workers' compensation benefit are 70%-75% of pre-injury wages.

- ☐ **I choose not to use any available paid leave at this time.** I understand that I will not receive any regular salary payments from Beaumont 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 only receive 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: _____

TASB HR Services