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

EMPLOYER (NAME & ADDRESS INCL ZIP)

Enter Actual School Location Here

CARRIER/ADMINISTRATOR CLAIM NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #

PHONE #

SIC CODE: N/A

EMPLOYER FEIN: N/A

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)

Mississippi School Boards Workers' Compensation Trust
P.O. Box 203, Clinton, MS 39060
601-924-2001

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☑ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CorVel Corporation
P.O. Box 23489, Jackson, MS 39225
800-929-5893

CARRIER FEIN | POLICY/SELF-INSURED NUMBER | 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

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NOTICE OF PHYSICIAN CHOICE

Employee's Name: _____

Employer's Name: _____

Injury Date: _____

I am claiming to have sustained an injury involving my _____. (indicate part of body)

I am ☐ am not ☐ claiming that my medical condition is work related. (check one)

If work related:

I understand that under the Mississippi Workers' Compensation Law I have the right to choose one (1) physician to render treatment to me. I can either accept the physician to whom I am sent by 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. _____.

_____
Employee's Signature

_____
Date

Witnessed By: _____

_____

Copy to Employee, Employer and CorVel (within 24 hours)
Fax Number 1-866-434-4720

WORKERS' COMPENSATION
EXAMINATION AND WORK STATUS FORM
Mississippi School Boards Association
Workers' Compensation Trust

To be Completed by Employer

Claimant _____ SS# _____

Address _____ Date of Birth _____

City & State _____ Zip Code _____

Job Title _____ Phone _____

School: _____

DATE & TIME OF ACCIDENT/INJURY _____

NATURE OF INJURY _____

Employee's Signature _____ **Date** _____

Authorized Signature _____ **Date** _____

PHYSICIAN TO COMPLETE

DATE OF SERVICE _____

CURRENT COMPLAINT _____

DIAGNOSIS _____

Work Status:

_____Temporarily Unable to Return to Work

_____Return To Work On _____

_____Restrictions As Follows _____

_____Return to Work No Restrictions

Date of Follow-up Appointment (if applicable) _____

PHYSICIAN'S SIGNATURE _____ **DATE** _____

PHYSICIAN'S ADDRESS _____

PHONE # _____

****PLEASE FAX FORM TO THE CLAIMS ADMINISTRATOR, CORVEL CORPORATION**
Fax Number: 1-866-434-4720 Telephone: 601-863-2740

To obtain a Pre-certification of Medical Necessity: Call 1-800-278-6602

MISSISSIPPI SCHOOL BOARDS ASSOCIATION
WC Trust
A Workers' Compensation Program
msba

CORVEL

MEDICAL RECORDS AND HEALTH INFORMATION AUTHORIZATION

To: ALL HEALTHCARE PROVIDERS, PHYSICIANS, HOSPITALS, COMPANIES AND PHARMACIES

Name of Patient: _____ **Date of Birth:** _____

Date(s) of Service (if known): Any dates of services related to or associated with the reported work-related injury.

I, the undersigned, authorize the release or request to access to the information below for the medical record(s) of the above named individual.

PATIENT INFORMATION NEEDED FOR:

Administration of a Workers' Compensation Claim # _____

As requested by the individual, this disclosure is made for any or all of the following purposes:

- ✓ Workers' Compensation purposes
- ✓ Vocational Rehabilitation
- ✓ Disability Claim
- ✓ Utilization Review
- ✓ Bill Review
- ✓ Advocacy 24/7 Nurse Triage and/or other Nurse Hotlines
- ✓ Telehealth/Telemedicine consultation

INFORMATION TO BE RELEASED OR ACCESSED:

1. The information to be disclosed is medical information related to my **Body Part(s)**. Including the following* (but not including psychiatric/psychotherapy notes or records):

HIV Test Results	☐ YES	☐ NO
Information Related to	☐ YES	☐ NO

Drug or Alcohol Abuse

*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

2. Any person or facility that attends, treats, or examines, including but not limited to: All facilities and medical providers related to the care of **Claimant** is to make this information available to CorVel Corporation or any of its parents, subsidiaries, affiliates, or related companies (collectively, "CorVel") or any of its agents, representatives or independent contractors; and

3. **Informed Consent and Authorization to CorVel.** When relevant or necessary to my claim, CorVel may collect, store and disclose (without further authorization) any and all of my individually identifiable medical or health information, including but not limited to photographs, visual and/or audio recordings or information that may constitute biometric information under applicable law (whether obtained pursuant to this authorization or otherwise from any person or entity, including but not limited to written, video or oral medical or health information provided by me through Advocacy 24/7 Nurse Triage Services and/or other 24/7 CorVel hotline, as well as Telehealth/Telemedicine consultation) to any of the following: (a) any person or facility that attends, treats or examines me; (b) any person, entity, or facility that impacts the determination of my claim or coordinates my benefits, this includes but is not limited to workers' compensation and short-term disability claims; (c) my employer and its affiliates and their representatives, independent contractors and service providers that may receive any such information from my employer to the extent permitted by state or federal law; or (d) the Social Security Administration or a social security or vocational rehabilitation vendor. CorVel may use my information obtained pursuant to this Authorization in any other claim matter that CorVel may

administer or handle related to me. I also understand that CorVel's privacy policy can be found at https://www.corvel.com/privacy-policy.

4. I understand that the Identified Healthcare Providers are not conditioning my treatment, payment, enrollment, or eligibility for benefits on whether I agree to sign this Authorization.

5. I understand that the information disclosed pursuant to this Authorization may no longer be protected by a federal or other health privacy rules, such as privileges under state law, and may be subject to re-disclosure by the recipient.

6. I understand that the information disclosed pursuant to this authorization will be transferred to, stored, and processed in the United States of America. I understand that by signing this Authorization, I consent to my information being transferred to, stored, and processed in the United States of America.

7. I understand that I have the right to revoke this Authorization in writing at any time, by sending a written request to your CorVel representative. I also understand that in some instances I may have a right to have my medical records accessed, modified or deleted. In such instance, I will download and complete an Access Request Form found at www.CorVel.com/AccessRequestForm and submit the Access Request Form to a CorVel representative so that my request can be verified.

   I further understand that the effective date of my revocation will be the date CorVel receives it and that any revocation will be effective only to the extent that Identified Health Care Providers has not already taken action in reliance on this Authorization.

8. If this Authorization is being signed on behalf of a minor (under the age of 18) or an individual lacking the legal capacity to sign on his or her own behalf, the individual signing represents he or she has the legal authority to sign on behalf of the patient named above.

9. This Authorization shall expire at the close of the claim.

10. Subject to any such request, I consent and authorize the retention of my medical records in accordance with CorVel's document retention policies and/or as required under applicable law.

11. ☐ Check this box if you want to receive communications from CorVel about the information marked in the statement of purpose at the following phone number (_____) _____-_____.

    By checking the above box, I agree and consent to receive text messages about the items marked in the statement of purpose from CorVel at the above number, which may be sent by automatic means, including using an auto dialer. I understand that agreeing to receive such communications is not a condition of purchasing any goods, property or services. Further, I understand that the text communications may contain personal medical and/or financial related information about me. I also understand that CorVel will do its best to secure the information communicated to me in any text messages, but there is no guarantee that those text messages are secure. To stop receiving the text messages, I can text STOP in reply to the text messages at any time.

12. ☐ **Informed Consent to Telehealth Services**. By checking this box I agree, consent and authorize CorVel to use the telehealth practice platform for telecommunication for evaluating and assessing my medical condition, as well as any other necessary communication regard my claim, which may involve the electronic transmission of my personal medical information to healthcare professionals in other locations. I accept that CorVel professionals can connect interactive sessions using communication technologies, including telephone or synchronous audio and visual methods. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I also understand that the CorVel professionals or I can discontinue the session if it is felt that the videoconferencing connections are not adequate for the situation. I also authorize CorVel to document our conversations for purposes of my claim and understand that CorVel will use any record of my session only for (i) the services provided to me by CorVel, and/or (ii) education and training by CorVel. I also release CorVel from all liability from the taking and authorized use or disclosure of any record of me as described in this consent. I further agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and that my information will be kept private.

13. I acknowledge that I have received a signed copy of this consent and authorization and am signing this document voluntarily. A copy of this signed consent and authorization shall have the same effect as the original.

_____
Printed Name (of person giving authorization)

_____ _____
Signature of person giving authorization Date

_____
Relationship to Patient

RETURN THIS FORM TO CORVEL'S CLAIMS REPRESENTATIVE

CorVel
P.O. Box 23489 Jackson, MS 39225
Email: Jackson_enterprise_comp@CORVEL.com **or Fax: (866) 434-4720**
Phone: (601) 863-2740

CORVEL

Injured Worker's First Fill Prescription Form

Mississippi School Board (MSBA)

Employee Name: _____

Date of Injury:_____ SSN: _____

Injured Worker Instructions

On your first Pharmacy visit, please give this notice to any pharmacy listed on this insert. This will expedite the processing of your approved workers' compensation prescriptions, based on the parameters established by **Mississippi School Board.** With the CorVel pharmacy program, you do not need to complete any paperwork or claim forms. Simply present this CorVel First Fill Prescription Form to the pharmacy. You should not incur any costs or co-pays at the pharmacy and you will be allowed up to a 14-day supply of most medications.

Notice to Injured Worker and Pharmacy

This temporary First Fill card is only valid if used within 30 days of the reported date of injury. Temporary eligibility through this program allows for a one-time fill of prescription medications. For assistance with processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.**

Pharmacy Instructions

For assistance processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.** Please use the BIN, PCN, and RxGroup number below to process an online/electronic claim to CorVel:

CORVEL CVS CAREMARK

BIN:	**004336**
PCN:	**ADV**
RxGroup:	**RXFFWC7761554**
Member ID:	**See below to generate ID**

To generate member ID: The Injured Worker's 9 digit social security number plus 8 digit date of injury will be used as their 17 digit **member identification number** when processing their First Fill Prescription:
XXXXXXXXXMMDDYYYY

Below is a sample listing of some of the over 62,000 Participating Pharmacies in the CorVel Network. Please call **(800)563-8438** for a participating pharmacy near you.

CostCo Pharmacy	H.E.B. Pharmacies	Meijer Pharmacy	Smith's Food & Drug Centers
CVS	Hy-Vee Pharmacy	Publix Pharmacy	Target Pharmacy
Duane Reade	Ingles Pharmacy	Raley's Drug Center	Von's Pharmacy
Drug Mart	Kroger Pharmacy	Rite Aid Pharmacy	Wal-Mart Pharmacy
Fred's Pharmacy	Longs Drug Store	Safeway Pharmacy	Walgreens Pharmacy
Giant Eagle Pharmacy	Marc's Pharmacy	Sav-On Drug Store	Wegman Pharmacy

Opioid Safety: What you need to know

Opioid misuse and abuse is a growing concern in our country. You may be taking (or have taken) a prescribed opioid such as oxycodone or hydrocodone to help relieve pain. Drugs like these are generally safe when taken exactly as directed for a limited period, but can become harmful—even fatal—if misused. It's important to be informed about the risks and benefits of opioid medication use should your doctor prescribe them to manage your pain.

Prescription opioids can help to manage short-term pain that may occur after a surgery or recent injury. But they may not work as well to manage chronic pain long-term. In addition, you're more likely to overdose or become addicted when using opioids for a long time. An overdose can cause serious health problems or even death. There may be other treatments available with less serious risks. Work with your doctor to find the safest, most appropriate ways to manage your condition.

As many as

1 in 4

taking prescription opioids struggle with addiction when opioids are used long-term.[1]

Safety tips to consider when you are prescribed opioid medication:

- Always take your medication exactly as instructed by your doctor.
- Never share your opioids with others.
- Avoid alcohol and certain medications that may interact with your opioids.
- Review your medication list with your doctor or pharmacist.
- Follow up regularly with your doctor.
- Store opioids in a secure place, ideally a locked location.
- Dispose of unused opioids properly. Check with your pharmacy regarding safe disposal methods.

Please note: Some insurance plans may allow opioid fills with a limited day supply. Please call **CorVel Pharmacy Solutions at 800-563-8438** with any questions regarding your plan.

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1. Prescription opioid overdose data. U.S. Centers for Disease Control and Prevention. Last updated August 1, 2017. https://www.cdc.gov/drugoverdose/data/overdose.html. Accessed January 10, 2018.

This information is not a substitute for medical advice or treatment. Talk to your doctor or health care provider about this information and any health-related questions you have. CVS Caremark assumes no liability whatsoever for the information provided or for any diagnosis or treatment made as a result of this information.

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