District Name:	Poteet ISD

EMPLOYEE REPORT OF INJURY INCIDENT

PRINT all information on this form.
This checklist is to be completed by the INJURED EMPLOYEE with assistance from his/her immediate supervisor as necessary.
This packet is VERY TIME SENSITIVE.
All forms in this packet should be completed the same day that the incident occurs - NOT LATER than 24 hours after the occurrence.
The completed form should be signed by the injured employee and the supervisor.
This form must be included in the Incident Investigation Packet submitted to *SchoolComp*.

SECTION I: EMPLOYEE PERSONAL INFORMATION

First Name, Middle Initial, Last Name			SS#
Male Female	Date of Birth (Mo, Day, Yr)	Married	Single Divorced
Ethnicity: (Hispanic, Native American, Other)	Race: Asian, Black, White		Home Phone #
Home Address:			Cell Phone #
Spouse's Name:	Email Address:		# Dependent Children:

SECTION II: INJURY INCIDENT INFORMATION

Work Location	Job at Time of Incident	
Date of Hire	Work Phone #	Best Time to Call:
Date of Incident (Month, Day, Year)	Day of Week (Mon, Tue, Wed....)	Time of Day ☐ AM ☐ PM
Exact Location of Incident (Football field, classroom, cafeteria, etc. Please be specific)		
Detailed Description of Incident (In Your OWN Words) :		
Print Name of Supervisor		
Specific Body Part Injured: (Left leg, right hand, etc. Please be SPECIFIC)		
Names of ALL Witnesses		
Did you seek treatment from a clinic, hospital, or doctor for this injury? ☐ Yes ☐ No		When?
Name of Treating Physician	Physician's Phone #	

I hereby certify that the above information is true and correct to the best of my knowledge. I authorize any and all providers of medical treatment deemed necessary in regard to my reported occupational injury or illness to release any medical information acquired in the course of my treatment to my employer and Creative Risk Funding, Inc.

Employee Signature	Date
Supervisor Signature	Date

District Name:	Poteet ISD

IMMEDIATE SUPERVISOR REPORT OF EMPLOYEE INJURY

PRINT all information on this form.
This is to be completed by the immediate supervisor of the injured employee.
This packet is VERY TIME SENSITIVE.
The Supervisor Report should be completed the same day that the incident occurs - NOT LATER than 24 hours after the occurrence.
The completed form should be signed by the supervisor.
This form must be included in the Incident Investigation Packet forwarded to the Workers' Compensation Coordinator at the district and must be submitted to *SchoolComp*.

Name of Injured Employee	Job Title
Date and Time this Incident was Reported to You:	
To what specific task was the worker assigned at the time of the incident?	
Was the assigned task part of the employee's regular job?	
If "NO", please explain:	
List safety equipment needed for this task:	
Was safety equipment being used by the injured worker at the time of the incident?	

Date of Incident (Month, Day, Year)	Day of Week (Mon, Tue, Wed....)	Time of Day ☐ AM ☐ PM
Exact Location of Incident (Football field, classroom, cafeteria, etc. Please be specific)		
Detailed Description of Incident (In Your OWN Words) :		
Specific Body Part Injured: (Left leg, right hand, etc. Please be SPECIFIC)		
Did the employee do anything, or fail to do anything that contributed to the injury? If yes, please explain:		

Did employee lose time from work?	Yes	No	First date unable to report for work
Has employee returned to work?	Yes	No	If "NO", date expected to return
Were District Safety Rules Violated?	Yes	No	If Yes, was Employee Counseled?
What steps will you take as supervisor to prevent future occurrences of this incident?			

Phone number to reach Supervisor or direct phone number for Supervisor	
Printed Name of Supervisor completing this form	Position
Supervisor Signature	Date

District Name:	Poteet ISD

WITNESS REPORT OF EMPLOYEE INJURY

PRINT all information on this form. This is to be completed by **any** witness to an employee injury.
This form should be completed **INDEPENDENTLY**, with no conversation between the witness and the injured employee.
This Witness Report is VERY TIME-SENSITIVE.
All forms in this packet should be completed the same day that the incident occurs - NOT LATER than 24 hours after the occurrence.
The completed form should be given to the supervisor of the injured employee for inclusion in their Incident Investigation Packet submitted to ***SchoolComp***.

Name of Injured Employee		Name of Witness Completing Report
Date of Incident	Day-of-the-Week	Time of Incident: ☐ AM ☐ PM
Location of Incident		
Specific Body Part Injured (left arm, right elbow, etc.)		
Description of Injury		

Detailed Description of Incident:
Did the employee do anything, or fail to do anything that contributed to the injury? ☐ Yes ☐ No
If "Yes", please explain:
In your opinion, how could this injury have been prevented?
List any other witnesses that were present at the time of the injury incident:

I hereby certify that the above information is true and correct to the best of my knowledge. I will provide further information about this incident to my employer or Creative Risk Funding, Inc. at any time.

Witness Phone Number	Number	
Witness Signature	Date	Printed Name
Supervisor Signature	Date	Printed Name

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: _____
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.

TASB RISK FUND

TASB Risk Management Fund
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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:

_____

_____

Poteet 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 Suzanne Jenschke, Superintendent's Secretary

Phone (830) 276-8202

Fax (830) 742-8038

Email sjenschke@poteetisd.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

Poteet 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.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services, Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."

tmesys®

IMP14-1813-37

Employee Notice of Alliance Requirements

Important Contact Information

To locate a provider, go to **www.pswca.org**.
To contact your adjuster at the TASB Risk Management Fund, visit **www.tasbrmf.org** or call 800.482.7276.

Information, Instructions, Rights, and Obligations

If you are injured at work, tell your supervisor or employer immediately. The information in this notice will help you to seek medical treatment for your injury. Your employer will also help with any questions about how to get treatment. You may also contact your adjuster at the TASB Risk Management Fund (the Fund) for any questions about treatment for a work related injury. The Fund is your employer's workers' compensation coverage provider and they are working with your employer to ensure you receive timely and appropriate health care. The goal is to return you to work as soon as it is safe to do so.

How do I choose a treating doctor?

If you are hurt at work **and** you live in the Alliance service area, you are required to choose a treating doctor from the provider list. This is required for you to receive coverage of healthcare costs for your work related injury. A provider listing is available through the Alliance website at **www.pswca.org** and a link to that site is also contained on the Fund's website at **www.tasbrmf.org**. It identifies providers who are taking new patients.

If your treating doctor leaves the Alliance, we will tell you in writing. You will have the right to choose another treating doctor from the list of Alliance doctors. If your doctor leaves the Alliance and you have a life threatening or acute condition for which a disruption of care would be harmful to you, your doctor may request that you treat with him or her for an extra **90 days.**

What if I live outside the service area?

If you believe you live outside of the service area, you may request a service area review by calling your adjuster.

How do I change treating doctors?

Within the first 60 days of beginning treatment, if you become dissatisfied with your first choice of a treating doctor, you can select an alternate treating doctor from the list of Alliance treating doctors in your service area. The Fund will not deny a choice of an alternate treating doctor. **However, before you can change treating doctors a second time, you must obtain permission from your adjuster.**

How are treating doctor referrals handled?

Referrals for health care services that you or your doctor request will be made available on a timely basis as required by your medical condition. Referrals will be made **no later than 21 days** after the request. Your doctor should refer you to another Alliance provider unless it becomes medically necessary to make a referral outside of the Alliance. You do not have to get a referral if you are in need of emergency care.



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Who pays for the healthcare?

Alliance providers have agreed to seek payment from the Fund for your health care. They should not request payment from you. If you obtain health care from a doctor who is not in the Alliance without prior approval from your adjuster, you may have to pay for the cost of that care and your income benefits may be disputed. You may treat with medical providers that are **not contracted** with the Alliance only if one of the following situations occurs:

- Emergencies: You should go to the nearest hospital or emergency care facility.
- You do not live within an Alliance service area.
- Your treating doctor refers you to a provider or facility outside of the Alliance. This referral must be approved by your adjuster.

How to File a Complaint

You have the right to file a complaint with the Alliance. You may do this if you are dissatisfied with any aspect of direct contract program operations. This includes a complaint about the program and/or your Alliance doctor. It may also be a general complaint about the Alliance. A complainant can notify the Alliance Grievance Coordinator of a complaint by phone, from the Alliance website **www.pswca.org** or in writing via mail or fax. Complaints should be forwarded to:

PSWCA (The Alliance)
Attention: Grievance Coordinator
P.O. Box 763
Austin, TX 78767-0763
866-997-7922

A complaint must be filed with the program grievance coordinator **no later than 90 days from the date the issue occurred**. Texas law does not permit the Alliance to retaliate against you if you file a complaint against the program. Nor can the Alliance retaliate if you appeal the decision of the program. The law does not permit the Alliance to retaliate against your treating doctor if he or she files a complaint against the program or appeals the decision of the program on your behalf.

What to do when you are injured on the job

If you are injured while on the job, tell your employer as soon as possible. A list of Alliance treating doctors in your service area may be available from your employer. A complete list of Alliance treating doctors is also available online at **www.pswca.org**. Or, you may contact us directly at the following address and/or toll-free telephone number:

TASB Risk Management Fund
P.O. Box 2010
Austin, TX 78768
800.482.7276

In case of an emergency

If you are hurt at work and it is a life threatening emergency, you should go to the nearest emergency room. If you are injured at work after normal business hours or while working outside your service area, you should go to the nearest care facility. After you receive emergency care, you may need ongoing care. You will need to select a treating doctor from the Alliance provider list. This list is available online at **www.pswca.org**. If you do not have internet

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access call 800.482.7276 or contact your employer for a list. The doctor you choose will oversee the care you receive for your work related injury. Except for emergency care you must obtain all health care and specialist referrals through your treating doctor.

Emergency care does not need to be approved in advance. "Medical emergency" is defined in Texas laws. It is a medical condition that comes up suddenly with acute symptoms that are severe enough that a reasonable person would believe that you need immediate care or you would be harmed. That harm would include your health or bodily functions being in danger or a loss of function of any body organ or part.

Non-emergency care

Report your injury to your employer as soon as you can. Select a treating doctor from the Alliance provider list. This list is available online at **www.pswca.org**. If you do not have internet access, call 800.482.7276 or contact your employer for a list.

Treatments Requiring Advance Approval

Certain treatments or services prescribed by your doctor need to be approved in advance. Your doctor is required to request approval from the TASB Risk Management Fund before the specific treatment or service is provided. For example, you may need to stay more days in the hospital than what was first approved. If so, the added treatment must be approved in advance.

The following non-emergency healthcare treatment requests must be approved in advance:

- Inpatient hospital admissions
- Outpatient Surgical or ambulatory surgical services
- Spinal Surgery
- All non-exempted work hardening
- All non-exempted work conditioning
- Physical or occupational therapy except for the first twelve (12) visits if those visits were done within the first 6 months immediately following date of injury or date of surgery
- Any investigational or experimental service
- Psychological testing exceeding 3 hours with no more than four tests, such as MMPI2, BDI, BAI, P-3
- Repeat psychological testing
- Psychotherapy and cognitive/behavioral therapy greater than 6 visits, repeat psychological interviews and biofeedback
- Repeat diagnostic studies greater than $350.
- All durable medical equipment (DME) in excess of $500
- Chronic pain management and interdisciplinary pain rehabilitation
- Drugs not included in the TDI Division of Workers' Compensation Formulary
- All narcotic medications dispensed greater than 60 days
- Any treatment or service that exceeds the Official Disability Guidelines

The number your doctor must call to request one of these treatments is 800.482.7276, x6654. If a treatment or service request is denied, we will tell you in writing. This written notice will have information about your right to request a reconsideration or appeal of the denied treatment. It will also tell you about your right to request review by an Independent Review Organization through the Texas Department of Insurance.

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