

Sharyland ISD Workers' Compensation Program

CRITICAL WARNING TO EMPLOYEES: These are the **ONLY** doctors and/or facilities that are approved for Workers' Compensation medical treatment. Except for life-threatening emergencies, you must seek care from an approved network provider listed below to receive full medical benefits under the district's self-insurance policy.

Module 1: Network Contacts & Claims Management

Service / Role	Provider / Contact	Phone Number	Details
Third-Party Claims Administrator	TRISTAR Risk Management	Direct: (361) 857-0115 Toll-Free: 1-888-55-TRISTAR	Manages accepted medical claims under the self-insurance policy.
Pharmacy Network Provider	AspenCompRX	(888) 356-3332	Pharmacy helpdesk for work-related injury prescriptions and first-fill processes.
Sharyland ISD HR Workers' Comp Specialist	Angela Uribe-Montes	(956) 584-6400 ext. 1108	Email: auribe-montes@sharylandisd.org
Sharyland ISD Main Office	Human Resources	(956) 580-5200	1200 N. Shary Rd., Mission, TX 78572

Module 2: Step-by-Step Reporting Procedures

Step 1: Seek Emergency or Initial Medical Care

- **For True Emergencies:** Call an ambulance or report directly to the closest hospital ER.
- **For Non-Emergencies:** Report your condition to your direct campus supervisor within 24 hours of the injury.
 - *Maintenance employees* must notify **Maricela Espinosa** at ext. 1076.
 - *Transportation employees* must notify **Ysaura Garza** at ext. 2810.

Step 2: Request the Verification of Coverage Form

- Before your first medical appointment or pharmacy visit, locate the Workers' Compensation Verification of Coverage form attached to this packet. Present it to the doctor and pharmacist to ensure medical bills are routed correctly to TRISTAR.

Step 3: Secure Your Work Status Report (DWC-073)

- You are **required** to obtain a completed Texas DWC-073 Work Status Report from your medical provider at the conclusion of *every single medical appointment*.

Step 4: HR Return-To-Work Clearance

- **Do not return to your campus or workspace without clearance.** Fax your DWC-073 to (956) 580-5224 or email it directly to Angela Uribe-Montes. Human Resources must review and issue a formal *Return to Work Status (RTW)* clearance before you can resume duties.

Module 3: Approved Primary Care & MD General Practice Directory

Specialty	Facility / Provider	Address	Phone
Family Practice / Urgent Care	Valley Day & Night Clinic	305 E Expressway 83, Mission, TX 78572	956-585-7401
Family Practice	Industrial Health Works Family Day & Night Clinic <i>Provider: Ashley Bose, MD</i>	801 E Nolana, Suite 9, McAllen, TX 78504	956-668-7333
Family Practice	McAllen Primary Care Clinic / McAllen Family Urgent Care <i>Provider: Dr. Sergio Diaz, MD</i>	110 East Savannah, A204, McAllen, TX 78503	956-686-4040
General Practice	Rio Occupational Institute, LLC <i>Provider: Dr. Mario Vasquez Aguilar, MD</i>	2501 Buddy Owens Blvd., McAllen, TX 78504	956-631-6109

Employee's Claim for Compensation for a Work-Related Injury (DWC1)

Claim for workers' compensation must be filed by the injured employee or by a person acting on the injured employee's behalf **within one or two days** of the date of injury.

I. INJURED EMPLOYEE INFORMATION

Name (First, Middle, Last)		Social Security Number		Date of birth (mm / dd / yyyy)	
Address (street, city/town, state, zip code, county, country)					
Phone Number		E-Mail address		Sex ☐ Male ☐ Female	
Race / Ethnicity ☐ White, not of Hispanic Origin ☐ Black, not of Hispanic Origin ☐ Hispanic ☐ Asian or Pacific Islander					
Do you speak English? ☐ Yes ☐ No If no, specify language _____					
Marital status ☐ Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced					
Campus / Department Location:			Work Scheduled _____: _____AM / _____: _____PM		
Occupation at time of injury		Work Phone Extension:		Work status ☐ Full-Time ☐ Part-Time	
Complete Address of Campus or Department Location:					
Was Employee Doing Regular Job? ☐ Yes ☐ No				Date of hire (mm / dd / yyyy)	

II. INJURY INFORMATION

Nature of Injury (Skip, Fall, Contusion, Etc.)	Date of Injury (mm / dd / yyyy)	Time of Injury
Location of Injury (Classroom, Gym, Hallway, Etc.)	Cause of Injury (Tool, Backpack, Chair, Etc.)	
Witness(es) to the Injury (list by name)		
Describe cause of injury, including how it is work related		
Body part(s) affected or exposed by the injury		

III. EMPLOYER INFORMATION (at the time of injury)

Employer name	Employer address (street, city/town, state, zip code, county, country)
Employer phone number	Supervisor name

IV. DOCTOR INFORMATION Do you wish to see a Doctor? ☐ Yes ☐ No

Name of treating doctor	Phone number
Address (street, city/town, state, zip code)	
Could this accident have been prevented? ☐ Yes ☐ No Yes, how	

Print Name of person filling out this form on behalf of injured employee

Date _____

Signature of injured employee

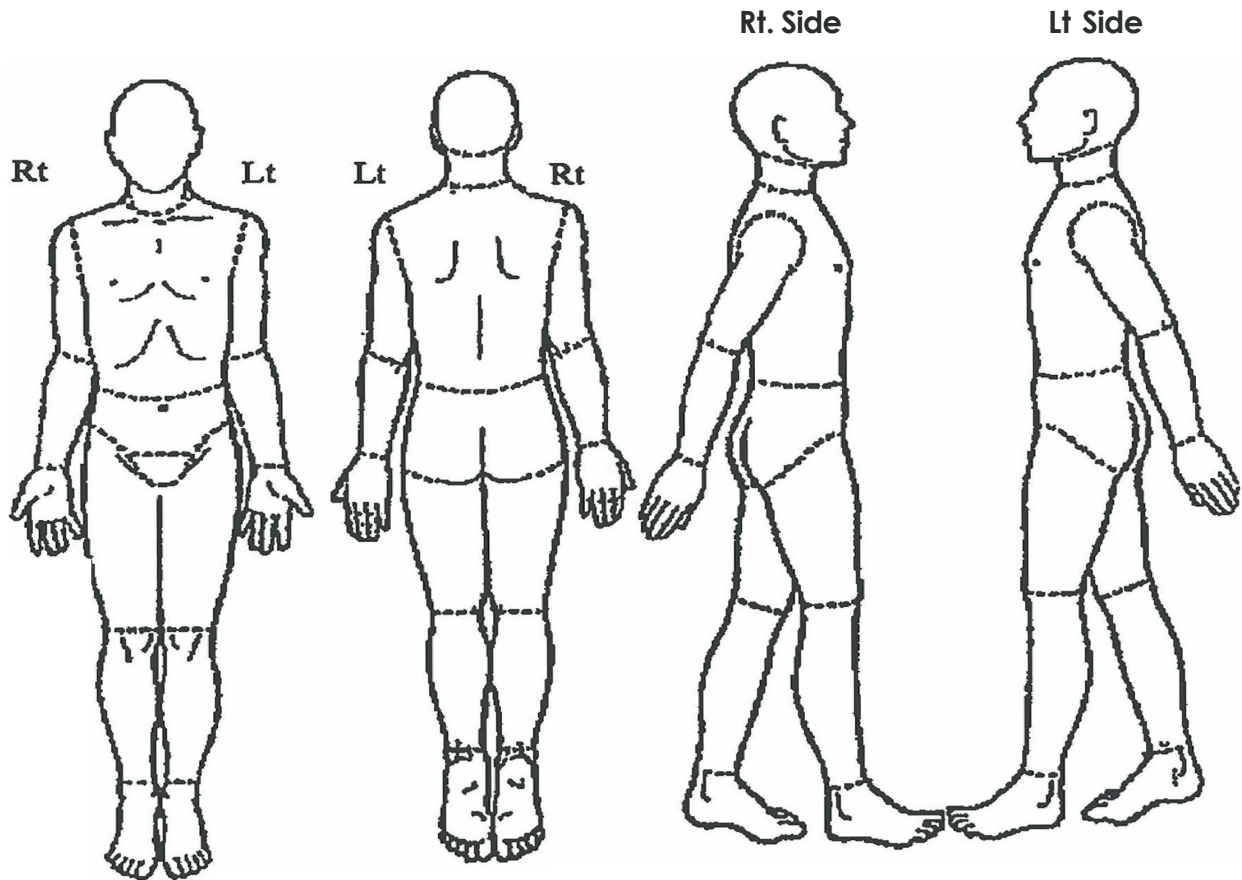
Date _____

Sharyland Risk Management Program

Body Diagram

Name: _____ SS#: XXX-XX-_____ DOI: _____

On the diagram provided below, please circle the parts of your body where you are experiencing pain due to this injury.



- I hereby certify that the information above this form is true and correct to the best of my knowledge.
- I understand that any falsification of information regarding an on-the-job or illness may result in disciplinary action and or prosecution under the appropriate State Criminal Statutes.

Employee's signature

Date

Sharyland I.S.D.
Human Resources
1200 N. Shary Rd., Mission, TX 78572
956-584-6400 x 1108

WORKERS' COMPENSATION VERIFICATION OF COVERAGE

Take this Form to Doctor's, Hospital Visit or Pharmacy with Prescription

(Name) _____ has reported a work-related injury/ illness that occurred on
(DOI) _____. This may be covered under Workers' Compensation benefits. Contact Tristar Risk Management at
the address below to authorize reasonable and necessary medical treatment, and to file expenses incurred for this claim.

Mail Claims to:
Tristar Risk Management
PO BOX 2805
Clinton, Iowa 52733-2805

Phone: (361) 857-0115 Fax: (361) 857-0123

Amy Kwast - Claim Supervisor
Amy.Kwast@tristargroup.net

Esta Behrens - Claim Examiner III
Esta.Behrens@tristargroup.net

Anna Garcia - Claims Examiner I
Anna.Garcia@tristargroup.net

Lizette Silguero - Claims Assistant
Lizette.Silguero@tristargroup.net

Attention Doctor's
Office

FAX

DWC73 to 956-580-5224
as soon as possible



AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

The undersigned authorizes the medical provider designated below to disclose specified medical records to a designated recipient. The medical provider shall not condition treatment, payment, enrollment, or eligibility for benefits on the submission of this authorization.

The disclosure of records authorized herein is required for the administration of a claim.

Medical provider: _____

Patient name: _____

Medical record number: _____

Date of birth: _____

Address: _____

Telephone number: _____

Claim number: _____

Email: _____

Recipient name: TRISTAR through its Copy Service Agent

Recipient address: P.O. Box 2805, Clinton, IA 52733-2805

Recipient telephone number: (800)593-0020

Health information requested:

X All medical records.

Purpose: Processing / administration of _____'s workers' compensation claim.

Note: records may include information related to mental health, alcohol or drug use, and HIV or AIDS. However, treatment records from mental health and alcohol or drug departments and results of HIV tests will not be disclosed unless specifically requested (check all that apply):

- ☐ Mental health records.
- ☐ Alcohol or drug records.
- ☐ HIV test results.

Method of delivery of requested records:

- ☐ Mail
- ☐ Pick up
- ☐ Electronic delivery, recipient email: _____

This authorization is effective until the workers' compensation claim is fully resolved or unless a different date is specified here _____(Date).

This authorization may be revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request.

A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization.

Notice: Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient signature*: _____

Date: _____

Print name: _____

*If not signed by the patient, please indicate relationship to the patient (check one, if applicable):

- ☐ Parent or guardian of minor patient who could not have consented to health care.
- ☐ Guardian or conservator of an incompetent patient.
- ☐ Beneficiary or personal representative of deceased patient.



Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System

As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). This assistance is offered at local offices across the State. These local offices also provide other workers' compensation system services from the Texas Department of Insurance (TDI). TDI is the State agency that administers and regulates the workers' compensation system through the Division of Workers' Compensation (DWC).

Many services provided by OIEC and DWC can be completed over the telephone. You can contact OIEC by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). Additional information, including office locations, is available on the Internet at: www.oiec.texas.gov. You can contact DWC by calling the toll-free telephone number 1-800-252-7031. Information about DWC is available on the Internet at: www.tdi.texas.gov.

Your Rights in the Texas Workers' Compensation System:

1. You have the right to hire an attorney to help you with your workers' compensation claim.

For assistance locating an attorney, contact the State Bar of Texas' lawyer referral service at 1-877-983-9227 or <http://www.texasbar.com/>. Attorney referral information can also be found on OIEC's website at www.oiec.texas.gov.

2. You have the right to receive assistance from OIEC if you do not have an attorney.

OIEC Customer Service Representatives and Ombudsmen are available to answer your questions and provide assistance with your workers' compensation claim by calling OIEC or visiting an OIEC office. **You must sign a written authorization before an OIEC employee can access information on your claim.** Call or visit an OIEC office to fill out the written authorization. Customer Service Representatives and Ombudsmen are trained in the field of workers' compensation and can help you with scheduling a dispute resolution proceeding about your workers' compensation claim. An Ombudsman can also assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot make decisions for you or give legal advice.

3. You may have the right to receive medical and income benefits regardless of who was at fault for your injury, with certain exceptions. Your beneficiaries may be entitled to death and burial benefits.

Information about the exceptions can be found at www.tdi.texas.gov or by visiting with OIEC staff.

4. You may have the right to receive medical care to treat your workplace injury or illness for as long as it is medically necessary and related to the workplace injury.

You may have the right to reimbursement of your incurred expenses after traveling to attend a medical appointment or required medical examination if the trip meets qualifying conditions.

5. You may have the right to receive income benefits for your work-related injury.

There are several types of income benefits and eligibility requirements. Information on the types of income benefits that may be available and the eligibility requirements can be found at www.tdi.texas.gov or by visiting with OIEC staff.

6. You may have the right to dispute resolution regarding income and medical benefits.

You may request Medical Dispute Resolution if you disagree with the insurance carrier regarding medical benefits. You may request Indemnity (Income) Dispute Resolution if you disagree with the insurance carrier regarding income benefits. The law provides that your dispute proceedings will be held within 75 miles from your residence.

7. You have the right to choose a treating doctor.

If you are in a Workers' Compensation Health Care Network (network), you must choose your doctor from the network's treating doctor list. You may change your treating doctor once without network approval. If you are not in a network, you may initially choose any doctor who is willing to treat your workers' compensation injury; however,

changing your treating doctor must be pre-approved by the DWC if you are not in a network. If you are employed by a political subdivision (e.g. city, county, school district,) you must follow its rules for choosing a treating doctor. It is important to follow all the rules in the workers' compensation system. **If you do not follow these rules, you may be held responsible for payment of medical bills.** OIEC staff can help you to understand these rules.

8. You have the right for your workers' compensation claim information to be kept confidential.

In most cases, the contents of your claim file cannot be obtained by others. Some parties have a right to know what is in your claim file, such as your employer or your employer's insurance carrier. Also, an employer that is considering hiring you may get limited information about your claim from DWC.

Your Responsibilities in the Texas Workers' Compensation System

1. You have the responsibility to tell your employer if you have been injured at work while performing the duties of your job. You must tell your employer within 30 days of the date you were injured or first knew your injury or illness might be work-related.

2. You have the responsibility to know if you are in a Workers' Compensation Health Care Network (network).

If you do not know whether you are in a network, ask the employer you worked for at the time of your injury. If you are in a network, you have the responsibility to follow the network rules. If there is something you do not understand, ask your employer or call OIEC. If you would like to file a complaint about a network, call TDI's Customer Help Line at 1-800-252-3439 or file a complaint online at <http://www.tdi.texas.gov/consumer/complfrm.html#wc>.

3. If you worked for a political subdivision (e.g., city, county, school district) at the time of your injury, you have the responsibility to find out how to receive medical treatment.

Your employer should be able to provide you with the information you will need in order to determine which health care providers can treat you for your workplace injury.

4. You have the responsibility to tell your doctor how you were injured and whether the injury is work-related.

5. You have the responsibility to send a completed Employee's Claim for Compensation for a Work-Related Injury or Occupational Claim Form (DWC041) to DWC.

You have one year to send the form after you were injured or first knew that your illness might be work-related. Send the completed DWC041 form even if you already are receiving benefits. You may lose your right to benefits if you do not timely send the completed claim form to DWC. For a copy of the DWC041 form you may contact DWC or OIEC.

6. You have the responsibility to provide your current address, telephone number, and employer information to DWC and the insurance carrier. DWC can be contacted at 1-800-252-7031.

7. You have the responsibility to tell DWC and the insurance carrier anytime there is a change in your employment status or wages. (Examples of changes include: you stop working because of your injury; you start working; or you are offered a job).

8. Eligible beneficiaries or persons seeking death and burial benefits have the responsibility to send a completed Beneficiary Claim for Death Benefits (DWC-042) to DWC within one year following the employee's date of death.

9. You are prohibited from making frivolous or fraudulent claims or demands.