Programa de Compensación para Trabajadores de Sharyland ISD

ADVERTENCIA CRÍTICA PARA LOS EMPLEADOS: Estos son los ÚNICOS médicos y/o instalaciones autorizados para el tratamiento médico de Compensación para Trabajadores. Excepto en caso de emergencias de por vida, debe buscar atención de un proveedor de la red aprobado que se enumera a continuación para recibir todos los beneficios médicos bajo la póliza de autoaseguro del distrito.

Módulo 1: Contactos de la Red y Gestión de Reclamaciones

Servicio / Rol	Proveedor / Contacto	Número de Teléfono	Detalles
Administrador de Reclamaciones de Terceros (TPA)	**TRISTAR Risk Management**	Directo: (361) 857-0115 Línea Gratuita: 1-888-55-TRISTAR	Gestiona las reclamaciones médicas aceptadas bajo la póliza de autoaseguro del distrito.
Proveedor de la Red de Farmacias	**AspenCompRX**	(888) 356-3332	Servicio de asistencia de farmacia para recetas de lesiones laborales y procesos de primer llenado.
Especialista en Compensación Laboral de Recursos Humanos	**Angela Uribe-Montes**	(956) 584-6400 ext. 1108	Correo electrónico: auribe-montes@sharylandisd.org
Oficina Principal de Sharyland ISD	**Recursos Humanos**	(956) 580-5200	1200 N. Shary Rd., Mission, TX 78572

Módulo 2: Procedimientos de Reporte Paso a Paso

Paso 1: Busque Atención Médica Inicial o de Emergencia

- **Para Emergencias Reales:** Llame a una ambulancia o diríjase directamente a la sala de emergencias del hospital más cercano.
- **Para Casos que No Sean Emergencias:** Reporte su condición a su supervisor directo del campus dentro de las 24 horas posteriores a la lesión.

- Los empleados de *Mantenimiento* deben notificar a **Maricela Espinosa** en la ext. 1076.

- Los empleados de *Transporte* deben notificar a **Ysaura Garza** en la ext. 2810.

Paso 2: Solicite el Formulario de Verificación de Cobertura

- Antes de su primera cita médica o visita a la farmacia, localice el formulario de Verificación de Cobertura de Compensación para Trabajadores adjunto a este paquete. Preséntelo al médico y al farmacéutico para garantizar que las facturas médicas se envíen correctamente a TRISTAR.

Paso 3: Asegure su Informe de Estado De Trabajo (DWC-073)

- Es **obligatorio** obtener un Informe de Estado de Trabajo de Texas (DWC-073) completo de su proveedor médico al finalizar *cada cita médica*.

Paso 4: Autorización de Regreso al Trabajo de Recursos Humanos

- **No regrese a su campus o espacio de trabajo sin autorización.** Envíe su DWC-073 por fax al (956) 580-5224 o por correo electrónico directamente a Angela Uribe-Montes. Recursos Humanos debe revisar y emitir una autorización formal de *Estado de Regreso al Trabajo (RTW)* antes de que pueda reanudar sus tareas.

Módulo 3: Directorio Aprobado de Atención Primaria y Práctica General Médica

Especialidad	Instalación / Proveedor	Dirección	Teléfono
Práctica Familiar / Clínica de Urgencias	**Valley Day & Night Clinic**	305 E Expressway 83, Mission, TX 78572	956-585-7401
Práctica Familiar	**Industrial Health Works Family Day & Night Clinic** ***Proveedor: Ashley Bose, MD***	801 E Nolana, Suite 9, McAllen, TX 78504	956-668-7333
Práctica Familiar	**McAllen Primary Care Clinic / McAllen Family Urgent Care** ***Proveedor: Dr. Sergio Diaz, MD***	110 East Savannah, A204, McAllen, TX 78503	956-686-4040
Práctica General	**Rio Occupational Institute, LLC** ***Proveedor: Dr. Mario Vasquez Aguilar, MD***	2501 Buddy Owens Blvd., McAllen, TX 78504	956-631-6109

Sharyland Independent School District

Human Resources:
Workers' Compensation Program

❖ Envíe el formulario completo por correo electrónico a la Especialista de seguros o por fax al 956-580-5224.

Formulario de reclamación del empleado de indemnización por una lesión relacionada con el trabajo
(DWC1)

El reclamo de compensación laboral debe ser presentado por el empleado lesionado o por una persona que actúe en nombre del empleado lesionado dentro de uno o dos días de la fecha de la lesión.

I. INFORMACIÓN DEL EMPLEADO LESIONADO

Nombre (Nombre, Segundo, Apellido)	**Número de Seguro Social**	**Fecha de nacimiento** (m / d /a)
Dirección (calle, ciudad/pueblo, estado, código postal, condado, país)		
Número de teléfono	**Correo electrónico**	**Sexo** ☐ Masculino ☐ Femenino
Raza / Etnicidad Blanca Negra o africana americana Hispano Orta asiática _____		
¿Hablas inglés? ☐ Sí ☐ No Si no, especifique el idioma		
Estado civil ☐ Casada ☐ Viudo ☐ Separado ☐ Soltero ☐ Divorciado		
Ubicación del campus / departamento:	**Horario programado:** __ _____AM / _____: _____PM	
Ocupación en el momento de la lesión	**Extensión del teléfono del trabajo:**	**Estado laboral** ☐ Tiempo completo ☐ Tiempo parcial
Dirección completa de la ubicación del campus o departamento:		
¿El empleado estaba haciendo un trabajo regular? ☐ Sí ☐ No		**Fecha de contratación** (m / d / a)

II. INFORMACIÓN SOBRE LESIONES

Naturaleza de la lesión (salto, caída, contusión, etc.)	**Fecha de la lesión** (m / d / a)	**Hora de la lesión**
Ubicación de la lesión (aula, gimnasio, pasillo, etc.)	**Causa de la lesión** (herramienta, mochila, silla, etc.)	
Testigo(s) de la lesión (lista por nombre)		
Describir la causa de la lesión, incluyendo cómo está relacionada con el trabajo		
Parte(s) del cuerpo afectada(s) **o expuesta(s) por la lesión**		

III. INFORMACIÓN DEL EMPLEADOR (en el momento de la lesión)

Nombre del empleador	**Dirección del empleador** (calle, ciudad/pueblo, estado, código postal, condado, país)
Número de teléfono del empleador	**Nombre del supervisor**

IV. INFORMACIÓN DEL MÉDICO ¿Desea ver a un médico? ☐ Sí ☐ No

Nombre del médico tratante	**Número de teléfono**
Dirección (calle, ciudad/pueblo, estado, código postal)	
¿Podría haberse evitado este accidente? ☐ Sí ☐ No	**En caso afirmativo, ¿cómo?**

Imprimir Nombre de la persona que llena este formulario en nombre del empleado lesionado _____ **Fecha** _____

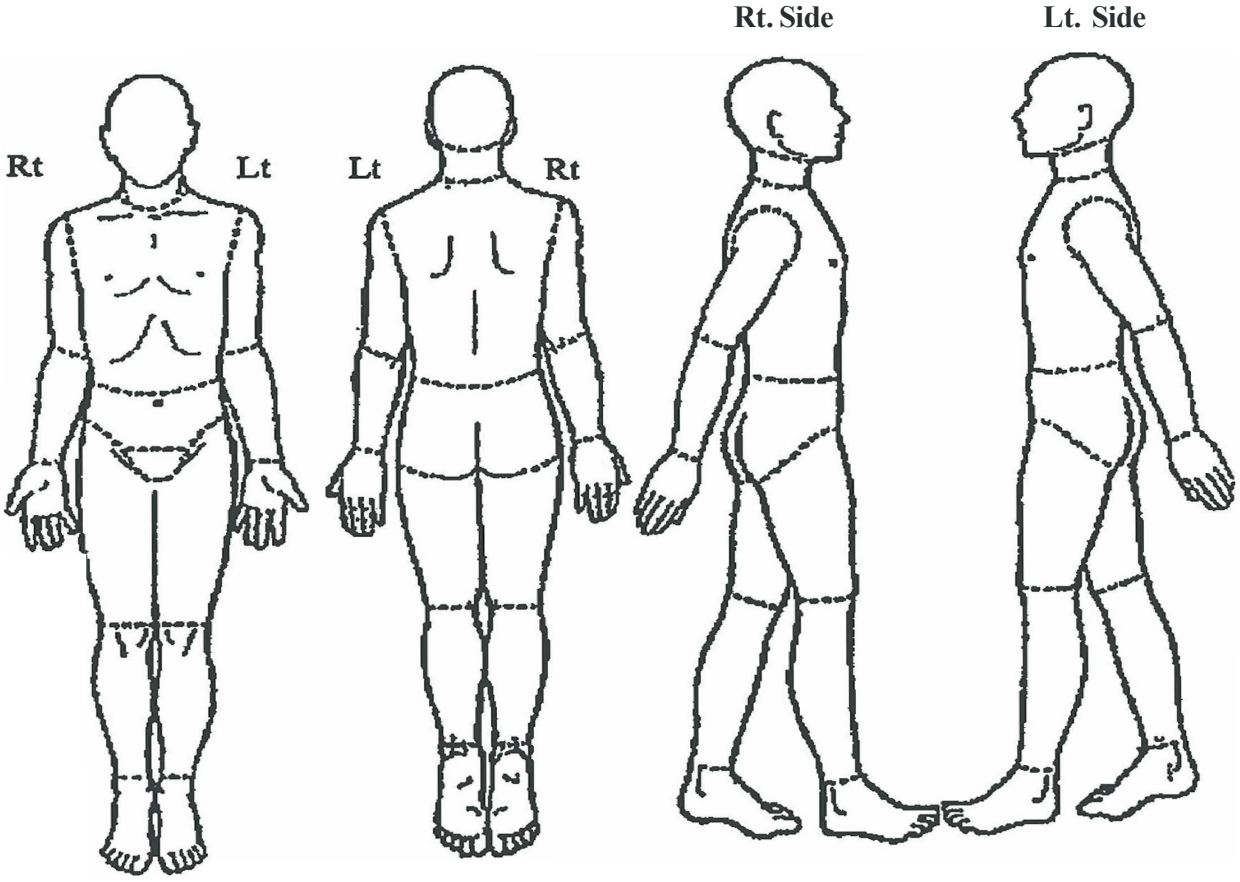
Firma del empleado lesionado _____ **Fecha** _____

Sharyland Risk Management Program
Diagrama del cuerpo

Nombre: _____ Número de Seguro Social: XXX-XX- _____

Fecha de la lesion: _____

En el diagrama proporcionado a continuación, por favor. Circule las partes de su cuerpo donde experimenta dolor debido a esta lesión.



1. **Por la presente certifico que la información anterior a este formulario es verdadera y correcta a mi saber y entender.**
2. **Entiendo que cualquier falsificación de información con respecto a un trabajo o enfermedad puede resultar en una acción disciplinaria y/o enjuiciamiento bajo los Estatutos Penales Estatales apropiados.**

_____ _____

Firma del Empleado **Fecha**

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

VERIFICACIÓN DE COBERTURA DE COMPENSACIÓN PARA TRABAJADORES

Lleve este formulario al médico, visita al hospital o farmacia con receta

(Nombre) _____ ha reportado una lesión/enfermedad relacionada con el trabajo que ocurrió el (Fecha) _____. Esto puede estar cubierto por los beneficios de Compensación para Trabajadores. Póngase en contacto con Tristar Risk Management en la dirección a continuación para autorizar un tratamiento médico razonable y necesario, y para presentar los gastos incurridos por esta reclamación.

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

Lizette Silguero - Claims Assistant

Lizette.Silguero@tristargroup.net
ext. 3011

Attention Doctor's Office

FAX

DWC73 to 956-580-5224
as soon as possible

TRISTAR®

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.**