Workers Compensation Injury Packet

This packet is to assist school personnel in reporting workplace injuries so that workers compensation claims are handled correctly and efficiently. Please refer to the following list when an injury is reported in your building.

1. **First Report of Injury** – Must be completed by employee and their supervisor immediately, even if the employee is not planning to seek medical attention. Send completed form to Stacey Sasko at stacey.sasko@whitley.kyschools.us or fax to 606-549-7006.
2. **Employee signature sheet** – Must be signed by injured employee when injury is reported and sent to Stacey Sasko.
3. **Medical Waiver and Consent** – Should be signed by employee and sent to Stacey Sasko.
4. **List of approved physicians** – Employee must be seen for their injury by one of the physicians listed. Failure to use a doctor on the list will result in claim not being payed.
5. **Prescription ID** – Send a copy with injured employee to cover any prescriptions related to work injury.
6. **Provider introductory letter** – Employee should take with them when seeking medical attention. This gives the physician's office the necessary information about the workers comp carrier.
7. **Report of Medical Status** – Should be given to physician to complete and returned to Stacey Sasko.

IA-1 WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General

Employer (Name & Address incl. zip)

Whitley County School system
300 Main St
Williamsburg, KY 40769

Carrier/Administrator Claim Number

Report Purpose Code

Jurisdiction

Jurisdiction Claim Number

Insured Report Number

Employer's Location Address (if different)

Location No.

Sic Code

Employer FEIN

Phone No.
606-549-7000

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)
Personnel Cabinet, Division of Employee Relations
Workers Compensation Branch
501 High St, 3rd Floor
Frankfort, KY 40601
502-564-6847

Policy Period
To

☐ Check if self insured

Claims Admin (Name, Address & Phone Number)
CCMSI, Inc
P.O. Box 43909
Lousiville, KY 40253
866-320-8456
Mary Carney

Carrier FEIN

Policy Number or Self-Insured Number

Administrator FEIN

Agent Name & Code Number

Employee/Wage

Legal Name (Last, First, Middle)

Date of Birth

Social Security Number

Date Hired

State of Hire

Address (Incl. Zip)

Sex
☐ Male
☐ Female
☐ Unknown

Marital Status
☐ Unmarried/ Single/Div.
☐ Married
☐ Separated
☐ Unknown

Occupation/Job Title

Employment Status

Phone

No. of Dependents

NCCI Class Code

Wage Rate
$
☐ Day ☐ Week ☐ Month ☐ Other

Days Worked/WK

Hrs Worked per Day

Full Pay for Date of Injury? ☐ Yes ☐ No

Did Salary Continue? ☐ Yes ☐ No

Occurrence

Time Employee Began Work ☐ AM ☐ PM

Date of Injury or Illness

Time Occurred ☐ AM ☐ PM

Last Work Date

Date Employer Notified

Date Disability Began

Employer Contact Name/Phone Number

Type of Illness/Injury

Part of Body Affected

Did Injury/Illness Exposure Occur on Employer's Premises? ☐ Yes ☐ No

Type of Illness/Injury Code

Part of Body Affected Code

Department or location 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 the 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 Returned to Work

If Fatal, Date of Death

Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No

Were they used? ☐ Yes ☐ No

Treatment

Physician/Health Care Provider (Name & Address)

Hospital (Name & Address)

Initial Treatment
0 ☐ No Medical Treatment
1 ☐ Minor: By Employer
2 ☐ Minor Clinic/Hosp
3 ☐ Emergency Care
4 ☐ Hospitalized > 24 hr.
5 ☐ Future Major Medical/Lost Time Anticipated

Other

Witness to Accident (Name & Phone Number)

Date Administrator Notified

Date Prepared

Preparer's Name & Title

Preparer's Phone Number

IA-1 (2/95)

SEE NEXT PAGE FOR IMPORTANT STATE INFORMATION/SIGNATURE

Applicable in Alaska

A person who willfully makes a false or misleading statement or representation for the purpose of obtaining or denying a benefit or payment is guilty of theft by deception.

Applicable in Arkansas

Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully decreasing any claim for benefit or payment or obtaining or avoiding worker's compensation coverage or avoiding payment of the proper insurance premium (or who aids and abets for either said purpose), under this chapter shall be guilty of a Class D. felony.

Applicable in California

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Applicable in Connecticut

This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Applicable in Delaware and Oklahoma

Any person who, knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. The lack of such a statement shall not constitute a defense against prosecution under this section. *Delaware Statutes Regulation: Del #C Section 913(B)

Applicable in Florida

Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files any statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Applicable in Idaho

Any person who Knowingly and with the intent to injure, Defraud, or Deceive any Insurance Company, Files a Statement of Claim Containing any False, Incomplete or Misleading information is Guilty of a Felony.

Applicable in Indiana

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Kentucky and New York

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In New York, such person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in Michigan

Any person who knowingly and with intent to injure or defraud any insurer submits a claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to $5,000.00.

Applicable in Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Applicable in New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in Ohio

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Pennsylvania

Any person who knowingly and with intent to injure or defraud any insurer files a claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years or payment of a fine of up to $50,000.

Applicable in Utah

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

EMPLOYEE SIGNATURE: _____

IA-1 (2-95)

FORM 106
ADOPTED JULY 2003

COMMONWEALTH OF KENTUCKY
OFFICE OF WORKERS' CLAIMS
657 Chamberlin Avenue
FRANKFORT, KY 40601

MEDICAL WAIVER AND CONSENT

I, _____ having filed a claim for workers' compensation benefits, do hereby waive any physician-patient, psychiatrist-patient, or chiropractor-patient privilege I may have and hereby authorize any health care provider to furnish to myself, my attorney, my employer, its workers compensation carrier or its agent, the Division of Workers' Compensation Funds, the Uninsured Employers' Fund, or Administrative Law Judge any information or written material reasonably related to my work-related injury occurring on or about _____ any medical information relevant to the claim including past history of complaints of, or treatment of, a condition similar to that presented in this claim or other conditions related to the same body part.

Such information is being disclosed to the purpose of facilitating my claim for Kentucky workers' compensation benefits.

I understand I have the right to revoke this authorization in writing at any time, by sending written notification to each individual health care provider, but such revocation will not have any affect on actions taken prior to revocation. Moreover, inasmuch as KRS 342.020(8) requires a medical waiver to be executed, revocation may result in suspension or delay of the workers' compensation claim.

I understand that no medical provider may condition treatment or payment on whether I sign this medical waiver; however, I further understand that failure to sign this medical waiver may result in suspension or delay of the workers' compensation claim.

I understand that the information used or disclosed pursuant to this medical waiver may be subject to re-disclosure by the recipient.

This authorization shall remain valid for 180 days following its execution. A photocopy of the authorization may be accepted in lieu of the original.

The authorization includes, but is not restricted to, a right to review and obtain all copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

Signed at _____, Kentucky, this _____ day of _____, 20_____.

_____
Signature of Patient Or Personal Representative

Social Security Number: _____

_____
Witness Signature

_____
Description Of Personal Representative's Authority

KENTUCKY WORKERS' COMPENSATION AND HIPAA

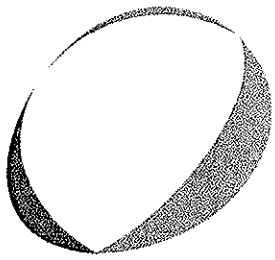
On April 14, 2003, the federal Health Insurance Portability and Accountability Act [HIPAA] privacy regulation will take effect. This regulation limits the situations in which medical providers may release patient information, unless the information is necessary for the purpose of treatment, payment, or health care operations. Moreover, it is important to note that disclosures for workers' compensation are in most instances exempt from HIPAA privacy requirements. The exact wording is as follows: "A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation..."

Since HIPAA defers to state law regarding disclosures relating to workers' compensation, it is important for claimants and medical providers to know what Kentucky law requires for disclosure of patient information. An employee who reports a work injury or who files for workers compensation benefits must "execute a waiver and consent of any physician-patient, psychiatrist-patient, or chiropractor-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation." KRS 342.020 (8). The reverse side of this Form 106 is the waiver and consent that each employee must sign. Kentucky law further states that once this Form 106 is signed, any health care provider "shall, within a reasonable time after written request by the employee, employer, workers' compensation insurer [or its agent or assignee], special fund, uninsured employers fund, or the administrative law judge, provide the requesting party with any information or written material reasonably related to any injury or disease for which the employee claims compensation."

Once the Form 106 is signed, health care providers may disclose information as set out in Kentucky law. Another section of the regulation allows release of information pursuant to an administrative or judicial order or subpoena, provided that there has been a reasonable effort to notify the injured worker [or his attorney] that such a request has been made. Should there be questions regarding disclosures pursuant to this form, appropriate legal counsel should be consulted or you can contact the Office of Workers' Claims at 800 554-8601.

Worker's Comp Approved Physicians

prov_id	name	address	city	state	zip	distance	phone	fax	specialty
12934991	Williamsburg Occupational Health Clinic	998 S Highway 25 W	Williamsburg	KY	40769	1.3	606-549-1183	606-549-8578	Occupational Medicine Clinic
902818	Jellico Community Hospital	188 Hospital Ln	Jellico	TN	37762	11.1	423-784-7252		General Acute Care
31979922	Whitley Family Medical Center	19 Medical Loop Ste 3	Whitley City	KY	42653	15.7	606-376-5391	888-960-2041	Family Practice
11719699	Cross, Trent W., MD	20405 Alberta St Ste A	Oneida	TN	37841	23.3	423-286-3400	423-286-3402	Family Practice
29388376	Perry, Kelvin D., MD	1 Trillium Way Ste 200	Corbin	KY	40701	13	606-528-5527	606-526-9687	Family Practice
29246278	Alnahhas, Mohamad H., MD	215 Treuhaft Blvd Ste 8	Barbourville	KY	40906	14.2	606-277-0173	606-277-0045	Family Practice
250698	Ashburn, William T., MD	215 N Allison Ave	Barbourville	KY	40906	17.4	606-546-9287	606-546-9363	Family Practice
22777410	Baptist Health Occupational Medicine	95 Bryan Blvd Ste 201	Corbin	KY	40701	17.6	606-526-4590	606-526-0548	Occupational Medicine Clinic, Urgent Care Clinic
2934579	Moore, Paul Douglas, MD	402 Cumberland Ave	Williamsburg	KY	40769	0.7	606-549-2656		Family Practice
30196606	Barbourville ARH	80 Hospital Dr	Barbourville	KY	40906	17.5	606-546-4175		General Acute Care
34876194	ARH Family Health	34 Mary Alice Dr	Flat Lick	KY	40935	22.6	606-542-0146	606-542-0148	Urgent Care Clinic
21104939	Dialysis Services of London	306 South Plz	London	KY	40741	22.9	606-862-0110	606-862-0210	Urgent Care Clinic
8334757	Pineville Community Hospital Association	850 Riverview Ave	Pineville	KY	40977	24.5	606-337-3051		General Acute Care Hospital



Workers' Compensation Temporary Prescription ID

Dear Injured Worker:

Take this to your pharmacist when you fill your initial prescription(s). If you have any questions or need to locate a participating pharmacy, please contact PMOA at (800) 661-1494.

Employee
Name:_____

ID#:_____
Enter CCMSI, last 4 digits of Social Security number and Date of Accident (Example: CCMSI and the last four digits of their social is 1234 and date of accident was 12/20/2010)
The EXAMPLE ID# is: **CCMSI1234122010**

Attention Pharmacy:

Please use the following information to enter the claim. If you have any questions or problems, please call PMOA at (800) 661-1494

Plan	Enter Bin Number 004410
PCN	Enter Process Control Number EMR
Group	KPCENTA
ID	See above
Name	See above

If you need assistance, please contact the PMOA help desk at:

(800) 661-1494

Commonwealth of Kentucky

PROVIDER INTRODUCTORY LETTER

Dear Provider:

_____, is coming to you for a visit as an employee of Whitley County School system, who is a participant in the **comp mc** Managed Healthcare Plan of Kentucky. This letter does not confirm that the injury or condition is covered under Kentucky's workers' compensation coverage. The claims administrator, CCMSI, will make this determination.

As the employer we are working closely with our claims administrator, CCMSI, and **comp mc,** to facilitate timely and medically necessary treatment for all employees who are injured on the job. *Please note:* ***We often have modified duty available within the capabilities/limits you assign.***

For Utilization and Case Management contact COMP MC
Phone: 866-361-6899 OR Louisville 502-394-3050 Fax: 502-426-9516
When one of the Following Occurs:

- Anticipated Disability 7 days or greater
- History of Prior disability-same body part
- Fractures
- Hospitalization
- Surgery anticipated
- Referral to Specialists
- Treatment Plan will exceed 2 weeks
- Physical Therapy is recommended

Emergency Room/Hospitals/Urgent Care Centers/Physicians: If the patient requires a referral to a specialist, consult the First Health Network Directory or call COMP MC, 866-361-6899.

Sincerely,

Employer Representative

COMMONWEALTH OF KENTUCKY/ CCMSI, INC. - REPORT OF MEDICAL STATUS

Employee Name:(First) (Middle Initial) (Last)	Date of Injury/Illness:
Is this Injury/Illness Work Related: ☐ YES ☐ NO	
Diagnosis:	

TO BE COMPLETED BY ATTENDING PHYSICIAN - PLEASE CHECK

I saw and treated this patient on _____ and:

☐ 1. Recommend patient return to work with no limitations on _____.
(Date)

☐ 2. Patient may return to work capable of performing the degree of work checked below with the following limitations:

Please Note: If limitations are noted a time limit must be indicated in Item #3 below!

PLEASE INDICATE DEGREE OF WORK

☐ **Sedentary Work:** Exerting up to 10 pounds of force occasionally and/or a negligible amount of force frequently to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

☐ **Light Work:** Exerting up to 20 pounds of force occasionally, and/or a negligible amount of force constantly to move objects. A job should be rated Light Work; (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling of arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible. NOTE: The constant stress and strain of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.

☐ **Medium Work:** Exerting 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly to move objects.

☐ **Heavy Work:** Exerting 50 to 100 pounds of force occasionally, and/or 25 to 50 pounds of force frequently, and/or 10 to 20 pounds of force constantly to move objects.

☐ **Very Heavy Work:** Exerting in excess of 100 pounds of force constantly and/or in excess of 50 pounds of force frequently, and/or in excess of 20 pounds of force constantly to move objects.

PLEASE INDICATE LIMITATIONS

Restricted Activities	May Perform Activity Occasionally	Frequently	Continuous
% of Assigned Shift	(1-33%)	(34-66%)	(67-100%)
Stooping	☐	☐	☐
Bending	☐	☐	☐
Lifting	☐	☐	☐
Reaching	☐	☐	☐
Pushing	☐	☐	☐
Pulling	☐	☐	☐
Walking	☐	☐	☐
Standing	☐	☐	☐
Twisting	☐	☐	☐
Turning	☐	☐	☐
Stretching	☐	☐	☐
Kneeling	☐	☐	☐
Climbing	☐	☐	☐
Above Shoulder Lifts	☐	☐	☐
Overhead Lifts	☐	☐	☐
Operation of Motorized Vehicle/Equipment /Machinery	☐	☐	☐

OTHER SPECIAL RESTRICTIONS:

(1) Occasional – Up to 2 ½ hours; (2) Frequent – Up to 5 ½ hours; (3) Continuous – More than 5 ½ hours
Based on a 7.5 hour workday – with morning and afternoon breaks.

☐ 3. These restrictions are in effect until _____ or until patient is re-evaluated on _____.

☐ 4. These restrictions are **PERMANENT.**

☐ 5. Patient is physically unable to return to work at this time. Patient will be re-evaluated on _____.

Physician's Signature:	**Date:**

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my attending doctor to release any information or copies thereof acquired in the course of my examination or treatment for the illness/injury identified above to my employer or representative.

Patient's Signature:	**Date:**

WCF-5
Rev. 2005