

INSTRUCTIONS: This checklist and attached forms are provided to assist the employee and supervisor in being certain that an injured employee gets proper medical care and timely pay. **The injured employee must be notified of all information below and the attached forms must be completed within the first occurrence of an injury.** These documents will be permanent record of the employee's Worker's Compensation claim. Mark each item with a check mark as discussed or note N/A if not applicable to this employee. Should you have any questions, please contact Risk Management at (956)523-4139 or (956)523-4143.



Webb County Worker's Compensation Checklist

1. All work-related injuries must be reported to Risk Management within 24 hours per County policy. Fill out 1st Report of Injury form (DWC-1) completely. First page must be sent to Risk Management within 24 hours of incident. CURRENT & ACCURATE EMPLOYEE HOME ADDRESS AND PHONE NUMBER MUST BE VERIFIED & LISTED. Item 51 must be signed by supervisor/manager/director, not the employee (DO NOT LEAVE BLANK).
2. Does employee require Medical Attention?
YES: Notify Risk Management at 523-4139 immediately so that a doctor's appointment can be made. The DWC-1 form (1st page) must be completed and faxed/mailed within 24hrs; the rest of the paper work must be submitted within a 72hr period. (For more information on Doctor Choice and visits refer to Webb County Policies & Procedures 10.04 Medical Attention, pg. 32)
NO: Fill out DWC-1 and submit a copy to Risk Management via interoffice mail, e-mail, or fax and note the form on top "**no medical attention needed at this time**" initial and date.
3. Did Employee go to the hospital? Yes No Hospital Name: _____
Is the employee a State Licensed Peace Officer? Yes No
Is employee payed through Grant Funds? Yes No Name of Grant: _____
4. If employee has been out or will be out more than 3 days, an FMLA form needs to be submitted. FMLA runs concurrent with Worker's Comp. If employee has been out over 90 days, they must, before they return, complete and pass a Return to Duty Drug & Alcohol Exam. **Therefore, Human Resources must be informed.** (Webb County Policies & Procedures 10.04 On-The-Job Injuries, pg. 31).
5. If receiving worker's compensation benefits, employee must pay Health Insurance Benefits in person to Risk Management Dept./Health Benefits. Payment must be in MONEY ORDER form only, no exceptions.
6. Open Communication must occur at ALL TIMES and be continuous between Employee, Department and Risk Management regarding doctor's visits, forms (work status forms) and all other relevant information pertaining to employee's work-related injury. Employee **MUST COMPLY** with all restrictions given by the treating physician. He/she must advise department of date doctor has released them to return to work immediately. (Webb County Policies & Procedures 10.04 Medical Attention, pg. 32)
5. All medical and physical therapy appointments pertaining to their on-the-job injury should be scheduled after or before work, if possible. Any time used for these appointments during regular work hours will be first taken from sick, annual, comp. time (if no time available, no pay). All appointments must be kept or rescheduled accordingly. (Webb County policies & procedures 10.04, pg. 31)
6. If an employee is released to return to work with restrictions the department **MUST** complete a Bonafide offer of employment/transmittal letter and DWC-6 Supplement Injury Form. If employee is released to return to work with modifications, all **MEANS SHOULD BE MADE BY WEBB COUNTY** to allow such accommodations. If the department **CAN NOT** accommodates the employee to return to work with modifications, the department must advise Risk Management in writing.
7. TIBS Eligibility (Temporary Income Benefits)
 - First 7 days out of work is counted against Sick Leave, Annual Leave, Comp. Time, or No pay. (10.04, pg. 31)
 - Worker's Comp benefits (TIBS) begins on 8th day out from work
 - Workers Comp benefits (TIBS) is 70% or 75% depending on current pay rate**Please Note: Peace officers are salary continuance & Sheriff Detention Officers (according to CBA).**
8. Copies of Notice of Injured Employee Rights and Responsibilities in Texas can be obtained from the Webb County "T" drive under Risk Management/Workers' Compensation, copies of 1st Report of Injury and Optum form. The Optum Worker's Compensation Temporary Prescription ID form is for obtaining medications. If there are any problems with obtaining medications, they must call the number listed on the form and advise TRISTAR and/or Risk Management.

Employee Name (PRINT)

Name & Title of Dept. Representative

Employee Signature

Today's Date:

FORM MUST BE SIGNED, COMPLETED AND SUBMITTED TO RISK MANAGEMENT DEPT

Rev:09/13/19at

Send the specified copies to your
Workers' Compensation Insurance Carrier
And the injured employee.

*Employers – Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filing.

CLAIM # _____

CARRIERS' CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F <u>M</u>	
3. Social Security Number	4. Home Phone	5. Date of Birth (m-d-y)	
6. Does the Employee Speak English? If No, Specify Language YES NO			
7. Race White Black Asian		8. Ethnicity Hispanic Native American Other	
9. Mailing Address Street or P.O. Box			
City	State	Zip Code	County
10. Marital Status Married Widowed Separated Single Divorced			
11. Number of Dependent Children		12. Spouse's Name	
13. Doctor's Name			
14. Doctor's Mailing Address (Street or P.O. Box)			
City	State	Zip Code	

15. Date of Injury (m-d-y)	16. Time of Injury : am pm	17. Date Lost Time Began (m-d-y)	
18. Nature of Injury*		19. Part of Body Injured or Exposed*	
20. How and Why Injury/Illness Occurred*			
21. Was employee doing his regular job?		22. Worksite Location Of Injury (stairs, dock, etc.) Garcia / San Bernardo	
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site			
Street or P.O. Box		County	
City	State	Zip Code	
24. Cause of Injury (fall, tool, machine, etc.)*			
25. List Witnesses			
26. Return to work date/or expected (m-d-y)	27. Did employee die? YES NO	28. Supervisor's Name	29. Date Reported (m-d-y)

30. Date of Hire (m-d-y)	31. Was employee hired or recruited in Texas? YES NO	32. Length of Service in Current Position Months _____ Years _____	33. Length of Service in Occupation Months _____ Years _____
34. Employee Payroll Classification Code		35. Occupation of Injured Worker	
36. Rate of Pay at this Job \$ _____ Hourly \$ _____ Weekly	37. Full Work Week Is: _____ Hours _____ Days	38. Last Paycheck was: \$ _____ for _____ Hours or _____ Days	39. Is employee an Owner, Partner, or Corporate Officer? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

40. Name and Title of Person Completing Form		41. Name of Business	
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone		43. Business Location (if different from mailing address) Number and Street	
City	State	Zip Code	City State Zip Code
44. Federal Tax Identification Number 746001587	45. Primary North American Industry Classification System Code: (6 digit)	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.
48. Workers' Compensation Insurance Company Midwest Employers Casualty Grp; TRISTAR, P.O. Box 2805, Clinton, IA 52733-2805 (877)600-0860 FAX(210)404-0429		49. Policy Number 74-6001587	
50. Did you request accident prevention services in past 12 months? YES NO If yes, did you receive them? YES NO			
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) <u>X</u> _____ Date _____			





PATIENT'S INITIALS

P O BOX 2950 Clinton, IA 52733-2805 877-500-0860 Fax#210-404-0429

AUTHORIZATION of RELEASE of MEDICAL INFORMATION

Patient Name: Claim No.:

Patient Address/Telephone:

Social Security No. Date of Birth:

I, (patient's name), understand that this authorization is voluntary, and that I may refuse to sign this authorization, and that I may revoke this authorization at any time by sending my written revocation to the entity providing the information. I understand that the revocation will not apply to information that has already been released in response to this authorization.

This authorization shall remain in effect until the workers' compensation claim is fully resolved or unless a different date is specified here (Date).

I, (Patient's name), hereby authorize:

(Name and address of physician, health care provider, other entity or location authorized to use or disclose information)

to furnish information described and requested below concerning: Brenda Neal (Patient name) to TRISTAR through its copy service agent. This request is made for the sole purpose of processing/administration of workers' compensation claim.

Records: Check the box, initial and/or sign to specify type of information disclosed: Any and all records and dates of service, unless specific dates specified below:

- Medical Information
Drug / Alcohol Information
Results of an HIV / AIDS Test
Other:

A carbon, photo static, or thermo fax copy of this true release shall be as valid as the original.

Signature of Patient, Parent or Legal Guardian

Date

If signed by other than patient, indicate relationship



Webb County On-the-job Injury Safety Procedures Counseling Records

ATTACHMENT D

Print Employee Name _____

Type of Violation/Counseling

*** The Webb County Safety Manual states employees that perform an “unsafe act or violation of safety rules causes injury to an employee, the supervisor will pursue disciplinary action for the unsafe act or safety rule violation, not the injury. – Webb County Safety Manual, pg. 28**

Corrective Measures Taken (what has been done to prevent this from happening again):

Employee Comments:

Print Supervisor's Name: _____ **Signature** _____

Department _____

Print Employee's Name: _____ **Signature** _____

Date Completed: ____ / ____ / ____

IF, EMPLOYEE IS A CIVIL SERVICE EMPLOYEE. THE DEPT. MUST FOLLOW CIVIL SERVICE STEPS, & FORMS REGARDING PROGRESSIVE DISCIPLINE, IE. Verbal (written) Counseling, Written Reprimand, Suspension, Demotion, Termination



Optum
 PO Box 152539
 Tampa, FL 33684-2539

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 are included in the network.

Questions? Need Help?



1-866-845-7740

Tristar		Webb County	
CARRIER/TPA		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: Call 1-800-964-2531 to establish First Fill benefit eligibility and obtain the ID number for online adjudication of approved benefits for the injured worker.
 Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC	or	Envoy
RxBIN	004261		002538
RxPCN	CAL	or	Envoy Acct. #

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."



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Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO... EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:



Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.



Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.



La mayoría de farmacias forman parte de la red.

¿Tiene alguna pregunta?
¿Necesita ayuda?

 **1-866-845-7740**

Tristar		Webb County	
PORTADORA		EMPLEADOR	
NOMBRE DEL TRABAJADOR LESIONADO			
Please provide directly to Pharmacist			
NUMERO DE SEGURO SOCIAL		FECHA DE ALA LESION (AAMMDD)	
Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com .			

Attention Pharmacists: Call 1-800-964-2531 to establish First Fill benefit eligibility and obtain the ID number for online adjudication of approved benefits for the injured worker.
Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC	or	Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #

NOTA: Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.



Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

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