Eastern Panhandle Instructional Cooperative
EPIC
Serving the educational needs of the entire community

FY'25 Employee Accident/Incident Reporting

- This year we are using Workpartners for our Workers' Compensation Claims.
- Please remember **all employee incidents and accidents must be reported to EPIC HR within 24 hours** even if medical attention is not sought.
- The attached Employee Accident Reporting form doesn't provide a lot of room for detail, so please attach additional information if applicable. Be sure you indicate exactly what happened and exactly what is injured (example: left lower shin or right index finger)
- If an injury was sustained and pictures of the location where it took place are important to see what happened and/or pictures of the injury itself will help with the claim, please include those pictures when you file your report.

TO REPORT A CLAIM

1. **Report the incident/accident** to your supervisor or designee at the time it happens.

2. **Complete SECTION I of the attached Employee Accident Report** and provide a copy to your immediate supervisor or designee to be shared with EPIC HR. If medical attention is NOT sought, the report will be filed as an incident with EPIC HR.

3. **If medical attention IS sought:**
   - Please **give us** information about where you are planning to go for treatment and when. (It is recommended you call the facility first to ensure they accept workers' compensation claims. Not all medical facilities do.)

   - **Complete** the Workpartners' Workers' Compensation Authorization for Release of Protected Health Information form in this packet and submit it to EPIC HR. We will file the claim and a Claim # will be assigned.

   - **When you go to the doctor**, **give a copy** of the Employee Accident Form (that you completed Section I on) **to your treating Medical Provider**, and THEY will complete Section II and give a copy back to you. They should also FAX a copy to Workpartners at 412-454-8717.

   - **After you have been treated**, please contact EPIC HR to follow up and to discuss next steps. You may call Shannon Johnson at 304-596-2663 or email sdjohnson@wvesc.org.

Form OIC-WC-1

West Virginia Workers' Compensation
Employ ' and Physicians' Report of Occupational Injury or Disease

PLEASE PRINT OR TYPE

Section I — Employee's Claim Information

Insurer: **Third-Party Administrator:**

1. Name: (Last): (First): (M.I):

2. Address: **3. Telephone:** ( ) -

City: State: Zip: **4. Social Security No.:** - -

5. Date of Birth: _____/_____/_____ **6. Sex:** ☐ M ☐ F **7. Marital Status:**

8. Date of Injury or Last Exposure: _____/_____/_____ **Time:** ☐ a.m. ☐ p.m. **9. Time You Began Work on Date of Injury:** ☐ a.m. ☐ p.m.

10. Date You Stopped Working Due to Injury: _____/_____/_____

11. Have You Retired? ☐ yes ☐ no If "yes," what was the date you retired: _____/_____/_____

12. Employer's Name: Supervisor's Name:

Address:

City: State: Zip: Telephone: ( ) -

13. Job Title/Description:

14. Body Part(s) Injured:

15. Describe How Your Injury Occurred (Specify the cause, what you were doing, and equipment/objects involved):

16. Did Injury Occur on Employer's Property? ☐ Yes ☐ No Address where injury occurred:

17. Please Identify Any Witnesses to Your Injury:

I certify that the above is true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I hereby authorize any physician, chiropractor, surgeon, practitioner or other healthcare provider, any hospital, including Veterans' Administration or governmental hospital, and medical service organization, any insurance company, any law enforcement or military agency, any government benefit agency including the Social Security Administration, or any other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to the diagnosis, treatment and/or counseling for HIV/AIDS, psychological conditions, and/or alcohol or substance abuse, for which I must give specific authorization. A Photostat of this authorization shall be as valid as the original.

Employee's Signature: _____ **Date:** _____/ _____/ _____

Section II — All Information Must Be Completed by Initial Healthcare Provider

1. Name of Physician/Hospital: **2. FEIN/Social Security No.:** - -

3. Address:

City: State: Zip: **Telephone:** ( ) -

4. Date of Initial Treatment: _____/_____/_____ **5. Date Patient May Return to Work:** _____/_____/_____

6. Have you advised the patient to remain off work 4 or more days?

☐ Yes. Indicate dates: from to

☐ No. If "no," is the patient capable of ☐ Full Duty ☐ Modified Duty If the patient is capable of returning to modified duty, specify any limitations/restrictions:

7. Condition is a direct result of: ☐ Occupational Injury? ☐ Occupational Disease? ☐ Non-Occupational Condition?

8. Did this injury aggravate a prior injury/disease? ☐ Yes ☐ No. If Yes, explain:

9. Description of injury or occupational disease:

10. Body part(s) injured: **11. ICD9-CM Diagnosis Code(s) in order of severity:**

12. Name of physician referred to: **13. If the patient was hospitalized, where?**

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge I have been informed of my responsibilities under West Virginia's Workers' Compensation Law and agree to abide by such in the administration of services provided thereunder. I understand the submission of false statements or billing may result in prosecution under state and federal law. I further agree to release any office notes/test results immediately to the employer or their representative.

Signature: _____ **Date:** _____/_____/_____

workpartners

WORKERS' COMPENSATION AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION

Employee's Full Name	**Claim Number**
Address	**Date of Birth**
City, State Zip Code	**Telephone Number**
Employer	

I hereby authorize the release of my protected health information (PHI) or other information relevant or potentially related to the injury or condition indicated below to WorkPartners, on behalf of UPMC Benefit Management Services, Inc. or UPMC Health Benefits, Inc., as applicable, its successors, or any of its authorized representatives (including attorneys working on its behalf) by all applicable medical practitioners, hospitals, other medical or medically related facilities, pharmacies, claims administrators, and insurers, including, but not limited to, those who administer Group Health, Short-Term Disability, Long-Term Disability, Workers' Compensation, Health and Wellness, Family Medical Leave, Disease Management, and rights under the Americans with Disabilities Act pursuant to my application for Workers' Compensation benefits.

Description of Injury or Condition: _____

Date of Injury or Condition: _____

Such disclosure may contain PHI or other information related to my Workers' Compensation medical condition or other condition(s) noted above, including, but not limited to, medical records, patient files, diagnosis, prognosis, progress notes, diagnostic and laboratory tests, treatment plan, prescriptions, wages, or earnings, provided all requests for this information are in writing.

I understand information received pursuant to this authorization may be used by WorkPartners for the investigation and determination of any applicable Workers' Compensation benefits to which I may be entitled. I understand that payment for treatment and benefits may be conditioned upon this authorization; I also understand that my healthcare provider will not condition my treatment based on this authorization. I understand this authorization is valid for the duration of my claim for Workers' Compensation, provided that such duration shall not exceed two years from the date of the signature on the following page.

I understand that WorkPartners may be required to disclose any and all facts related to my injury, illness, or disability to my employer-contracted benefit administrators or insurers (including health benefits provider(s); claims processors; case, disease, or health management companies, and insurers) to determine eligibility for health or disease management programs and for administration and operations of employer benefit plans (including but not limited to Short-Term Disability, Long-Term Disability, Workers' Compensation, coordination of care and quality assurance, health improvement, and utilization review programs).

I certify that all of the information that I have provided is, to the best of my knowledge, true, correct, and complete.

workpartners

IMPORTANT INFORMATION ABOUT YOUR RIGHTS

- I have a right to receive a copy of this authorization.
- I may revoke this authorization at any time before its expiration date by notifying WorkPartners in writing (*see* #2 on the next page), but the revocation will not have any effect on any actions taken before the revocation was received by WorkPartners.
- I understand that any of my PHI received by WorkPartners may be released to others in accordance with the terms of this authorization. Re-disclosure of my PHI by WorkPartners or any other party is not protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Please return this completed and signed form by fax to 412-454-8717 or by mail to WorkPartners, PO Box 2971 Pittsburgh, PA 15230.

1. Type of records to be released (check all that apply):

☑ Inpatient
☑ Outpatient
☑ Diagnostic testing
☐ Other: _____

☑ Emergency department
☑ Physician/Office
☑ Physical therapy

Unless you check the box(es) immediately below, no information about alcohol/substance abuse, HIV/AIDS or behavioral health will be disclosed:

☐ **YES**, disclose information related to alcohol/substance abuse
☐ **YES**, disclose Information Related To HIV/AIDS
☐ **YES**, disclose Behavioral Health Information

2. I may revoke this authorization by notifying:

UPMC Insurance Services Division
Attn: Chief Privacy Officer
600 Grant Street
Pittsburgh, PA 15219
HealthPlanCPO@upmc.edu

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature of Employee	**Date of Employee's Signature**	**Employee's Date of Birth or Claim Number**

OR, if applicable –

Signature of Parent, Legal Guardian or Authorized Representative	**Date of Parent, Legal Guardian or Authorized Representative's Signature**	**Description of Authority to Act for the Employee (i.e., Parent, Legal Guardian or Authorized Representative)**

A copy of this completed, signed and dated form must be given to the member or other signator.

Official Use Only

Received	**Processed By**	**Log #**

workpartners

Provider Information: please use additional sheets of paper as needed

---

Primary Care Physician Name: _____

Address: _____

_____

Telephone Number: _____

Treating Provider Name: _____

Address: _____

_____

Telephone Number: _____

Treating Provider Name: _____

Address: _____

_____

Telephone Number: _____

Diagnostic Testing Provider: _____

Address: _____

_____

Telephone Number: _____

Patient Name (print): _____

Patient Signature: _____

Date of Signature: _____

workpartners

myMatrixx
An Express Scripts Company

Workers' Compensation Temporary Prescription ID Card

West Virginia - Commercial

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 800.945.5951.

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame al Centro de Contacto para Atención a Clientes de Express Scripts, al 800.945.5951.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of $150. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance or exposure medications, call Express Scripts at 888.786.9640.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

Express Scripts

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____ / _____ / _____
MM/DD/YYYY

Group #: KYHA

Employee Date of Birth: _____ / _____ / _____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

workpartners

myMatrixx
An Express Scripts Company

Workers' Compensation Temporary Prescription ID Card

West Virginia - Commercial

Participating Retail Network Pharmacies

AccessHealth Pharmacy
Adkins Pharmacy
Beckley Pharmacy
Bond's Drug
Bypass Pharmacy
CAMC Pharmacy
Community Care
CVS
Drug Emporium
Food Lion
Fruth Pharmacy
Giant Eagle
Greenbrier Med Arts
Hart's Pharmacy
Kroger
Medicine Shoppe
Miller's Pharmacy
Reed's Pharmacy
Rite Aid
Sam's Club
Valley Pharmacy
Walgreens
Wal-Mart
Weis