

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. <u>Complete SECTION I of the attached Employee Accident Report</u> 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

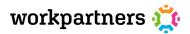
Signature:

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	
10. Date You Stopped Working Due to Injury:/		Injury: a.m. p.m.	
11. Have 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	re doing, and equipment/ol	ojects 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: Section II All Information Must Be Complet	ted by Initial Health	Date:///	
1. Name of Physician/Hospital:		N/Social Security No.:	
3. Address:	2. FEI	N/Social Security No	
City: State:	Zip:	Telephone: () -	
4. Date of Initial Treatment:/	*		
4. Date of Initial Treatment:/			
7. Condition is a direct result of: Occupational Injury? Occupational Disease? Non-Occupational Condition?			
8. Did this injury aggravate a prior injury/disease?			
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.			

Date: ___



WORKERS' COMPENSATION AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

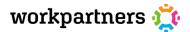
Employee's Full Name	Claim Number	
Address	Date of Birth	
City, State Zip Code	Telephone Number	
Employer		
I hereby authorize the release of my protected health potentially related to the injury or condition indicated Benefit Management Services, Inc. or UPMC Health Bits authorized representatives (including attorneys we practitioners, hospitals, other medical or medically reand insurers, including, but not limited to, those who Long-Term Disability, Workers' Compensation, Health Management, and rights under the Americans with D Workers' Compensation benefits.	d below to WorkPartners, on behalf of UPMC Benefits, Inc., as applicable, its successors, or any of orking on its behalf) by all applicable medical elated facilities, pharmacies, claims administrators, administer Group Health, Short-Term Disability, h and Wellness, Family Medical Leave, Disease	
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.

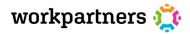


IMPORTANT INFORMATION ABOUT YOUR RIGHTS

- 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 rel	eased (check all that apply):		
	√. ☑ Inpatient		ency department	
	✓ Outpatient	☑ Physici		
	☐ Diagnostic testing	✓ Physica		
	☐ Other:	_ ,,		
				_
	Unless you check the b behavioral health will b		ormation about alcohol/substance	abuse, HIV/AIDS or
	☐ YES , disclose informa	ation related to alcohol/substance	abuse	
	☐ YES , disclose Informa	ation Related To HIV/AIDS		
	☐ YES , disclose Behavio	oral Health Information		
2.	I may revoke this author	ization by notifying:		
	UPMC Insurance Service	s Division		
	Attn: Chief Privacy Office	5 2 1 1 1 5 1 5 1 1		
	600 Grant Street	-		
	Pittsburgh, PA 15219			
	HealthPlanCPO@upmc.e	edu		
THIS F	ORM MUST BE FULLY COM	MPLETED BEFORE SIGNING.		
Signatur	re of Employee	Date of Employee's Signature	Employee's Date of Birth or Claim	-
Jigilatai	ie of Employee	bute of Employee's digitature	Number	
OR, if a	applicable –			
_	re of Parent, Legal Guardian	Date of Parent, Legal Guardian or	Description of Authority to Act for	_
or Autho	orized Representative	Authorized Representative's	the Employee (i.e., Parent, Legal	
		Signature	Guardian or Authorized Representative)	
	A copy of this comp	pleted, signed and dated form mu	ist be given to the member or othe	er signator.
		Official Use O	nly	
	Received	Proce	essed By	Log #



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:	





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

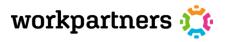
		Express Scripts	1
ID#: _			
		ary ID number; present to the pharmacy at the time will receive a new ID number shortly.	
Date o	of Injury:	// MM/DD/YYYY	
Group	#: KYHA		
Emplo	oyee Date of Bir	rth://	/

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		Last
	Street Address or PO Box	
City	State	ZIP
Employer Na	me	





Workers' Compensation Temporary Prescription ID Card West Virginia - Commercial

Participating Retail Network Pharmacies

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