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

Employee Accident/Incident Reporting

- For FY'23 we are using Encova Insurance for 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 Encova 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 Encova 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 1 of the attached Employee Accident Report** and provide a copy of the form to the 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 you are seeking treatment in to ensure they accept workers' compensation claims. Not all medical facilities do.)
   - EPIC HR will file the claim with Encova and a Claim # will be assigned to you.
   - You will give a copy of the Employee Accident Form (that you completed Section 1 on) to your treating Medical Provider, and THEY will complete Section 2 and file it with Encova and give a copy back to you.

If you have questions, please contact EPIC HR – sdjohnson@wvesc.org or 304-596-2663.

APPENDIX C

encova INSURANCE

WEST VIRGINIA WORKERS' COMPENSATION EMPLOYEES' AND PHYSICIAN'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

For Encova use only
Claim number:
Team assigned:

SECTION I - EMPLOYEE'S CLAIM INFORMATION

1. Last name	First name		MI
2. Address			3. Telephone
City	State	ZIP	4. Social Security number
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 parts 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 health care 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 valid as the original.

Employee's signature Date

SECTION II – ALL INFORMATION MUST BE COMPLETED BY INITIAL PROVIDER

1. Name of physician/hospital			2. FEIN/Social Security number
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 four or more days? ☐ Yes If 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. ICD10-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 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.

Physician's signature Date

General instructions for completing the "BI-1,"

"West Virginia Workers' Compensation Employees' and Physician's Report of Occupational Injury or Disease"

Please read carefully.

BI-1, West Virginia Workers' Compensation Employees' and Physician's Report of Occupational Injury or Disease: To be completed by the claimant and the medical provider.

This form should not be used to file occupational pneumoconiosis or hearing loss claims.

To the claimant: Section I of this form must be completed by you. **When you have completed this form, make a copy for your records and give a copy to your employer.** The initial medical provider is responsible for completing Section II of this form. If you do not receive a decision on your claim within **14 days** after submitting the form, contact Encova Insurance. To be eligible for benefits, **a claim must be filed with Encova within six months** from and after the injury or death. If you have any questions, contact Encova at 866-452-7425 or visit our website at encova.com.

To the initial medical provider: Section II of this form must be completed by you. The timely provision of information regarding the claimant's condition is vital in deciding eligibility for benefits. Each answer should be as specific as possible. You should immediately send a copy of all records, office notes and test results regarding the claimant's exam to Encova. **Please forward the original completed form to Encova and provide a copy to the claimant.** If you have any questions, contact Encova at 866-452-7425 or visit our website at encova.com.

Special instructions for Section I	
Question 8	This date is defined as either the date you were injured or the date you were last exposed if you are filing an occupational disease claim.
Question 13	Provide your specific job title and describe the duties of the job you are currently working.
Question 15	Please provide as much detail as possible and attach additional pages if space is needed.

Special instructions for Section II	
Question 1, 2	The group and FEIN are required by Encova for billing purposes.
Question 8	Describe in detail what effect, if any, the claimant's previous health may have on this injury.

Please attach additional pages if space is needed and include any appropriate reports.

Return completed form to

Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151

When completing this form, enclose attachments if additional space is needed.