MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

Please Enter Actual School Location Here

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE #

SIC CODE

EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)

Mississippi School Boards Workers' Compensation Trust
P.O. Box 203; Clinton, MS 39060
601-924-2001

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☑ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CorVel Corporation
PO Box 23489, Jackson, MS 39225
800-929-5893

CARRIER FEIN

POLICY/SELF-INSURED NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX

☐ MALE (M)
☐ FEMALE (F)
☐ UNKNOWN (U)

MARITAL STATUS

☐ UNMARRIED/SINGLE/DIVORCED (U)
☐ MARRIED (M)
☐ SEPARATED (S)
☐ UNKNOWN (K)

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

OF DEPENDENTS

NCCI CLASS CODE

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:

#DAYS WORKED WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

COUNTY 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 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 RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT

NO MEDICAL TREATMENT (0) ☐
MINOR: BY EMPLOYER (1) ☐
MINOR CLINIC/HOSP (2) ☐
EMERGENCY CARE (3) ☐
HOSPITALIZED > 24 HRS (4) ☐
FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) ☐

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

SEE BACK FOR INSTRUCTIONS

CORVEL

Injured Worker's
First Fill Prescription Form

Mississippi School Boards Association Workers' Compensation Trust (MSBA)

Employee Name: _____

Date of Injury:_____SSN:_____

Injured Worker Instructions

On your first Pharmacy visit, please give this notice to any pharmacy listed on this insert. This will expedite the processing of your approved workers' compensation prescriptions, based on the parameters established by **Mississippi School Board.** With the CorVel pharmacy program, you do not need to complete any paperwork or claim forms. Simply present this CorVel First Fill Prescription Form to the pharmacy. You should not incur any costs or co-pays at the pharmacy and you will be allowed up to a 14-day supply of most medications.

Notice to Injured Worker and Pharmacy

This temporary First Fill card is only valid if used within 30 days of the reported date of injury. Temporary eligibility through this program allows for a one-time fill of prescription medications. For assistance with processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.**

Pharmacy Instructions

For assistance processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.** Please use the BIN, PCN, and RxGroup number below to process an online/electronic claim to CorVel:

CORVEL CVS CAREMARK

BIN: **004336**
PCN: **ADV**
RxGroup: **RXFFWC7761554**
Member ID: See below to generate ID

To generate member ID: The Injured Worker's 9 digit social security number plus 8 digit date of injury will be used as their 17 digit **member identification number** when processing their First Fill Prescription:
XXXXXXXXXMMDDYYYY

Below is a sample listing of some of the over 62,000 Participating Pharmacies in the CorVel Network. Please call **(800)563-8438** for a participating pharmacy near you.

CostCo Pharmacy	H.E.B. Pharmacies	Meijer Pharmacy	Smith's Food & Drug Centers
CVS	Hy-Vee Pharmacy	Publix Pharmacy	Target Pharmacy
Duane Reade	Ingles Pharmacy	Raley's Drug Center	Von's Pharmacy
Drug Mart	Kroger Pharmacy	Rite Aid Pharmacy	Wal-Mart Pharmacy
Fred's Pharmacy	Longs Drug Store	Safeway Pharmacy	Walgreens Pharmacy
Giant Eagle Pharmacy	Marc's Pharmacy	Sav-On Drug Store	Wegman Pharmacy

Opioid Safety: What you need to know

Opioid misuse and abuse is a growing concern in our country. You may be taking (or have taken) a prescribed opioid such as oxycodone or hydrocodone to help relieve pain. Drugs like these are generally safe when taken exactly as directed for a limited period, but can become harmful—even fatal—if misused. It's important to be informed about the risks and benefits of opioid medication use should your doctor prescribe them to manage your pain.

Prescription opioids can help to manage short-term pain that may occur after a surgery or recent injury. But they may not work as well to manage chronic pain long-term. In addition, you're more likely to overdose or become addicted when using opioids for a long time. An overdose can cause serious health problems or even death. There may be other treatments available with less serious risks. Work with your doctor to find the safest, most appropriate ways to manage your condition.

As many as

1 in 4

taking prescription opioids struggle with addiction when opioids are used long-term.[1]

Safety tips to consider when you are prescribed opioid medication:

- Always take your medication exactly as instructed by your doctor.
- Never share your opioids with others.
- Avoid alcohol and certain medications that may interact with your opioids.
- Review your medication list with your doctor or pharmacist.
- Follow up regularly with your doctor.
- Store opioids in a secure place, ideally a locked location.
- Dispose of unused opioids properly. Check with your pharmacy regarding safe disposal methods.

Please note: Some insurance plans may allow opioid fills with a limited day supply. Please call **CorVel Pharmacy Solutions at 800-563-8438** with any questions regarding your plan.

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1. Prescription opioid overdose data. U.S. Centers for Disease Control and Prevention. Last updated August 1, 2017. https://www.cdc.gov/drugoverdose/data/overdose.html. Accessed January 10, 2018.

HIPAA AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, authorize the health care providers identified in paragraph 2 below to disclose protected health information ("PHI") about me as described in this Authorization:

1. The information to be disclosed is all medical documentation, including but not limited to medical history, consultation, prescription, or treatment, copies of hospital records, radiology reports, test results, x-ray, MRI, CT Scan and myelogram films or plates, clinic notes, including diagnostic and prognosis related to my work- related injury of _____ ("work injury").

2. _____ and any other health care provider or facility who treats me for my work injury ("Identified Health Care Providers") may disclose the above-described information to CorVel Corporation and/or Vocational Case Manager or Medical Case Manager employed by CorVel Corporation.

3. This disclosure is made for the following purposes: As requested by the individual for workers' compensation purposes.

4. I understand that the Identified Health Care Providers are not conditioning my treatment, payment, enrollment, or eligibility for benefits on whether I agree to sign this authorization.

5. I understand that the information disclosed pursuant to this authorization may no longer be protected by the federal health privacy rule and may be subject to re-disclosure by the recipient.

6. I understand that I have the right to revoke this authorization in writing at any time by sending a letter to the Privacy Officer of the Identified Health Care Provider and that the effective date of my revocation will be the date the Privacy Officer receives it. I further understand that any revocation will be effective only to the extent that Identified Health Care Providers has not already taken action in reliance on this authorization.

7. This Authorization shall expire twelve months from the date of signature.

_____
Name of Employer (School)

_____
Printed Name (Employee)

_____ _____
Signature (Employee) Date

_____
Witness

_____ _____
Relationship to Employee (supervisor, Principal etc) Date

NOTICE OF PHYSICIAN CHOICE

Employee's Name: _____

Employer's Name: _____

Injury Date: _____

I am claiming to have sustained an injury involving my _____. (indicate part of body)

I am _____ am not _____ claiming that my medical condition is work related. (check one)

If work related:

I understand that under the Mississippi Workers' Compensation Law I have the right to choose one (1) physician to render treatment to me. I can either accept the physician to whom I am sent by employer or choose someone else on my own.

I also understand that any referral to any other doctor must be made by my one chosen physician.

I also understand that my employer (or workers' compensation carrier) must approve any physician change and that if I change doctors without their authorization, I will be responsible for the medical expenses for the unauthorized treatment.

With that understanding, I state as follows:

- ❑ I accept as my choice of physician my employer's suggested physician to provide treatment and that choice is Dr. _____

- ❑ I elect to choose my own physician to provide treatment and that choice is Dr. _____

_____
Employee's Signature

_____
Date

Witnessed By: _____

_____

Copy to Employee, Employer and CorVel (within 24 hours)
CorVel Fax #: 866-434-4720

WORKERS' COMPENSATION
EXAMINATION AND WORK STATUS FORM
Mississippi School Boards Association
Workers' Compensation Trust

To be Completed by Employer

Claimant _____ SS# _____

Address _____ Date of Birth _____

City & State _____ Zip Code _____

Job Title _____ Phone _____

School: _____

DATE & TIME OF ACCIDENT/INJURY _____

NATURE OF INJURY _____

Employee's Signature _____ **Date** _____

Authorized Signature _____ **Date** _____

PHYSICIAN TO COMPLETE

DATE OF SERVICE _____

CURRENT COMPLAINT _____

DIAGNOSIS _____

Work Status:

_____Temporarily Unable to Return to Work

_____Return To Work On _____

_____Restrictions As Follows _____

_____Return to Work No Restrictions

Date of Follow-up Appointment (if applicable) _____

PHYSICIAN'S SIGNATURE _____ **DATE** _____

PHYSICIAN'S ADDRESS _____

PHONE # _____

****PLEASE FAX FORM TO THE CLAIMS ADMINISTRATOR, CORVEL CORPORATION**
Fax Number: 1-866-434-4720 Telephone: 601-863-2740

To obtain a Pre-certification of Medical Necessity: Call 1-800-278-6602

Mississippi School Board Association
Workers' Compensation Trust

Voluntary Witness Statement

Date Occurred:_____ Time Occurred:_____

Name of School/Address of School:_____
_____

Name of Person Giving Statement:_____

Home Address:_____

Work Phone: ( ) _____ Alt Phone: ( )_____

Statement is in regard to (name of person(s) involved in incident, if known):
_____

Location of Occurrence:_____

Did you see the incident occur: Yes or No (circle one)

Written Statement: Please describe in detail what you witnessed on the above date:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I have read this statement and I affirm to the truth and accuracy of the facts contained herein. This statement was completed at :

(location)_____ on the ____ day of _____, 20__ at _____ am/pm

_____ _____
Signature Person Making Statement Date:

_____ _____
Witness to Statement/Title Date