CHEROKEE COUNTY BOC

Workers' Compensation Accident Report Packet

Rev 12/12/18

Cherokee County Board of Commissioners
People Resources Department
1130 Bluffs Parkway – Canton, GA 30114
Phone: 678-493-6019 ~ Fax: 678-493-6017

Dear Employee:

Attached are County forms which provide information and guidance for employees' sustaining a Workers' Compensation injury. This packet is divided into sections for use by the employee/supervisor and it has a resource section containing additional forms which may be needed in some cases.

We want to ensure that employees are provided timely, efficient medical treatment from one of the Doctors on our Panel of Physicians or the Emergency Room if needed. Employees are required to immediately notify their supervisor of any on the job injury. The goal of Workers' Compensation is to provide appropriate medical care and return the employee to work as soon as medically possible.

If you have any questions, please contact me: 678-493-6019 or cell ~ 770-547-9293.

Best Regards,

Robert Alford
People Resources Manager

PART 1

Employee Section

CHEROKEE COUNTY WORKERS' COMPENSATION GUIDE

INSTRUCTIONS FOR THE INJURED EMPLOYEE

IF INJURY IS LIFE THREATENING ~ CONTACT 911 IMMEDIATELY!

What to do if I am injured on the job, need medical treatment, and can reach my supervisor:

- **Immediately** report the accident to your supervisor
- If injury is not life threatening - the following Workers' Comp forms need to be completed:
    1. Cherokee County Accident Investigation Report form
    2. Witness(es) complete and sign witness statement ~ **If applicable** ~ *Part #3*
    3. Sign form WC 107 for Release of Medical Information
    4. If Rx is needed, please use OPTUM for *"First Fill Rx"*
    5. Sign the Receipt of Notice of WC "Panel of Physicians" ~ *Circle selected Provider*
    6. Keep the **Employee** Copy
    7. Complete Exposure Incident Investigation Form ~ **If applicable**
    8. *If Dental injury ~ see Dental information sheet ~ Part #3*
    9. Drug test (10 Panel) is required anytime employee requires medical treatment

I am injured on the job (not life threatening) and need medical treatment and cannot reach my supervisor:

- If supervisor is not available ~ choose a provider from the WC "Panel of Physicians" and seek medical attention
- As soon as possible-contact your supervisor or designated department representative to complete the forms listed below

I am injured on the job and do not need medical treatment:

- Immediately notify your supervisor
- Complete the Cherokee County Accident Investigation Report form
- Witnesses complete and sign witness statement ~ **If applicable** ~ Part #3

DOT EMPLOYEES ~ (If 5 Panel Drug Test required) REPORT FOR ALCOHOL AND DRUG TESTING TO:

Optimal Health 1030 Marietta Rd, Canton, GA 30114 ~ Phone: 770-720-8668

**** After hours ~ use Northside Cherokee Hospital***

Questions may be addressed to: Robert Alford, People Resources Manager

~Office: 678-493-6019 Cell: 770-547-9293 ~ Fax: 678-493-6017~ Email: ralford@cherokeega.com

This notice must be posted in a conspicuous place readily accessible to the employee at all times.

OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days.

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least six physicians, including an orthopedic surgeon with no more than two physicians from industrial clinics. Further, this panel shall include one minority physician, whenever feasible (see Rule 201 for definition of minority physician). The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change of doctor, from the list, may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

State Board of Workers' Compensation
270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818 or 1-800-533-0682
http://www.ganet.org.sbwc/

PROVIDER LISTINGS

WORKERS' COMPENSATION ONLY

Be Advised the Panel may be updated from time to time. The current Panel will always be listed on the PRC Website- Workplace safety Tab.

CLINIC
Peachtree Immediate Care
720 Transit Ave Ste 101
Canton, GA 30114
770 720-7000

CLINIC
Northside Family Medicine & Urgent Care
684 Sixes RD. Suite 125
Holly Springs, GA 30115
678-426-5450

PRIMARY CARE PHYSICIAN
Wellstar Med Group & Urgent Care
Cherri Barton MD; Carlos Garcia MD
120 Stone Bridge Pkwy Ste 310
Woodstock, GA 30189
678-494-2500

ORTHOPEDIC SURGEON
Peachtree Orthopedic Clinic
Dr. Michael Bernot
2045 Peachtree RD. NE Ste 700
Atlanta, GA 30309
404-355-0743

OPTHALMOLOGIST
Marietta Eye Clinic
100 Old Ball Ground Hwy
Canton, GA 30114
770-479-2195

ORTHOPEDIC SURGEO N
Resurgens Orthopedics
Dr. Michele Perez
2230 Towne Lake Pkwy
Bldg#300 Suite #100
Woodstock, GA 30189
770-592-4424

PRIMARY CARE PHYSICIAN
Prestige Medical Group
684 Sixes Rd
Ste 105 Holly Springs, GA 30115
678-494-9669

ORTHOPEDIC SURGEON
NSide Cherokee Orthopedics
Dr. Steven Rodes
684 Sixes Rd. Ste 130
Holly Springs, GA 30115
770-517-6636

REHABILITATION
Physicians Spine & Rehab
5730 Glenridge Dr. Ste 100
Sandy Springs, GA 30328
404-816-3000

Additional doctors may be added on a separate sheet)
The insurance company providing coverage for this business under the Workers Compensation Law is: York Risk Group Service P.O Box 183188 Columbus,OH 43218

Name: Cherokee County Board of Commissioners	Address: 1130 Bluffs Parkway Canton, GA 30114	Radius: 31.9 mile(s)	Generated: 1/2/2018

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G.A. §34-9-18 and §34-9-19).

OPTUM Medical Pharmacy Program - To contact your local OPTUM Medical Pharmacy, please call (800) 547-3330.

Notify your immediate supervisor of your injury. If you feel that you need medical attention, you may choose one of the providers listed above. Please call the provider to confirm the address information and to schedule an appointment for faster service. Many clinics are open extended hours for your convenience. For Urgent Care needs after clinic hours, you may proceed to the nearest hospital. Patients will be seen on a medical priority basis. In emergency situations you may immediatey seek treatment from the nearest qualified facility or provider. If you need an alternative to the providers listed above, call 1-877-366-9413 .Cherokee County utilizes York Risk Group contracted providers. The above is not a complete list of healthcare providers with York Risk. If your situation is a medical emergency requiring immediate attention, dial 911 or proceed to the nearest hospital which provides emergency services. Use of this network does not confirm or verify compensability under the Georgia Workers' Compensation Act, which is determined by the claims administrator.

My signature acknowledges that I have been given a copy of the panel of physicians for Workers' Compensation injuries for the Cherokee County Board of Commissioners and have been notified that I may choose any provider from this list.

Name_____ **Date**_____

This notice must be posted in a conspicuous place readily accessible to the employee at all times.

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Name: Cherokee County Board of Commissioners	Address: 1130 Bluffs Parkway Canton, GA 30114	Radius: 31.9 mile(s)	Generated:1/2/2018

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Notify your immediate supervisor of your injury. If you feel that you need medical attention, you may choose one of the providers listed above. Please call the provider to confirm the address information and to schedule an appointment for faster service. Many clinics are open extended hours for your convenience. For Urgent Care needs after clinic hours, you may proceed to the nearest hospital. Patients will be seen on a medical priority basis. In emergency situations you may immediately seek treatment from the nearest qualified facility or provider. If you need an alternative to the providers listed above, call 1-877-366-9413. Cherokee County utilizes York Risk Group contracted providers. The above is not a complete list of healthcare providers with York Risk. If your situation is a medical emergency requiring immediate attention, dial 911 or proceed to the nearest hospital which provides emergency services. Use of this network does not confirm or verify compensability under the Georgia Workers' Compensation Act, which is determined by the claims administrator.

EMPLOYEE COPY

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

BILL OF RIGHTS FOR THE INJURED WORKER

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

Employee's Rights

1. If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.
2. Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.
3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job.
4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.
5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than $575 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-3818.
6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than $575 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more the $383 per week, not to exceed 350 weeks.
7. When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than $383 per week for no longer than 350 weeks.
8. Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to $7,500 and two-thirds of your average weekly wage, but not more than $575 per week. A widowed spouse with no children will be paid a maximum of $230,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.
9. If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.

Employee's Responsibilities

1. You should follow written rules of safety and other reasonable policies and procedures of the employer.
2. You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of your benefits.
3. An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.
4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.
5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.
6. A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.
7. You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when your were injured. If you do not attempt the job, your benefits may be suspended.
8. If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.
9. If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.
10. Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.
11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.
12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than $10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: http://www.sbwc.georgia.gov. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777- or 1-800 237-2629.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G.A. §34-9-18 and §34-9-19).

REVISION 07/20/2016

WC-207 AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

Instructions: This form shall not be filed with the Board, unless otherwise requested

TO: TREATING PHYSICIAN		
Print Name and Title		
Address		
City	State	Zip Code

RE: Employee / Patient		
Last Name	First Name	M.I.
SSN	Date of Injury	Birthdate

This document authorizes the release of only the medical information as provided below. The above-stated entity, facility or medical practitioner is authorized to release medical information to

CHEROKEE COUNTY BOARD OF COMMISSIONERS AND YORK RISK SERVICES GROUP

in accordance with applicable State and Federal laws.

The information covered by this Authorization and Consent to Release is that authorized by O.C.G.A. §34-9-207 which reads as follows:

(a) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury arising from the incident that the employee has had with any physician, including, but not limited to, communications with psychiatrists or psychologist. This waiver shall apply to the employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Notwithstanding any other provision of law to the contrary, when requested by the employer, any physician who has examined, treated, or tested the employee or consulted about the employee shall provide within a reasonable time and for a reasonable charge all information and records related to an examination, treatment, testing, or consultation concerning the employee.

(b) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, the employee, upon request, shall provide the employer with a signed release for medical records and information related to the claim or history or treatment of injury arising from the incident, including information related to the treatment for any mental condition or drug or alcohol abuse and to such employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Said release shall designate the provider to whom the release is directed. If a hearing is pending, any release shall expire on the date of the hearing.

(c) If the employee refuses to provide a signed release for medical information as required by this Code section and, in the opinion of the Board, the refusal was not justified under the terms of this Code section, then such employee shall not be entitled to any compensation at any time during the continuance of such refusal or to a hearing on the issues of compensability arising from the claim.

Federal regulations (42 CFR Part 2), and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 45 CFR 164.512(1) which reads as follows: *"The covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related illnesses or injury without regard to fault."* Anyone who receives information under this authorization receives the same under all limitations set forth in Federal and State law regarding further dissemination of such information.

This release shall expire in 180 days or upon written notice of revocation by the patient. If a hearing is pending, this release shall remain in effect until the hearing and shall expire on the date the hearing is held.

Employee / Patient Signature	**Date**

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

PART 2

Supervisor Section

CHEROKEE COUNTY WORKERS' COMPENSATION GUIDE

INSTRUCTIONS FOR SUPERVISOR OF THE INJURED EMPLOYEE

Employee is injured on the job and needs medical treatment:

IF INJURY IS LIFE THREATENING ~ CONTACT 911 IMMEDIATELY!

- **If injury is not life threatening complete the following forms:**
    1. Cherokee County Accident Investigation Report Form
    2. Witnesses complete the witness statement ~ **If applicable** ~ Part #3
    3. Have employee sign WC 107 Release of Medical Information
    4. If Rx is needed, please use OPTUM Access card for *"First Fill Rx"*
    5. Have employee sign receipt of the WC " Panel of Physicians" ~ give them a copy
    6. Complete Exposure Incident Report Form ~ **if applicable ~** Part #3
    7. Complete top section of York Risk Physician's Report/Pharmacy Guide*, give to employee to take to Medical Provider ~ If employee needs a Rx filled ~ bottom of form has information for OPTUM Medical Pharmacy Network ~ take to any Pharmacy*
    8. *Complete* Cherokee County Workers' Compensation Authorization for Treatment form for *employee to give to Medical Provider*
    9. Drug test (10 Panel) is required anytime employee requires medical treatment

Employee is injured on the job and does not need medical treatment:

- Complete the Accident Investigation Report form
- Witnesses complete the witness statement ~ **if applicable** ~ Part #3
- Drug test (10 Panel) is required if there is damage to County property or a motor vehicle accident

DOT EMPLOYEES ~ (If 5 Panel Drug Test required) REPORT FOR ALCOHOL AND DRUG TESTING TO:

Optimal Health 1030 Marietta Rd, Canton, GA 30114 ~ Phone: 770-720-8668

**** After hours ~ use Northside Cherokee Hospital***

Questions may be addressed to: Robert Alford, Human Resources Manager

~ Office: 678-493-6019 Cell: 770-547-9293 ~ Fax: 678-493-6017~ Email: ralford@cherokeega.com

Cherokee County Accident Investigation Report

Employee Name:	Employer's Premises: Yes ☐ No ☐ Off site: Yes ☐ No ☐	Date of Accident or illness:
Job Title:	Location of Accident:	Time of Accident ☐ AM PM ☐
Department:	Date Reported:	Has employee performed this job before? Yes ☐ ☐ No
Was any county property/equipment damaged? Yes ☐ No ☐ Property/Equipment Damaged:		Job being performed

What was employee doing when injury/illness occurred?

Describe in detail how accident occurred?

Part of body affected/injured? (be specific):

Nature of injury/illness (be specific):

PLEASE INDICATE IF ANY OF THE FOLLOWING CONTRIBUTED TO THE INJURY OR ILLNESS

____ Unsafe Act(s)
____ Employee Training
____ Insufficient Maintenance
_____Unsafe Conditions
____ Violation of Safety Rules
____Lack of Experience
____Improper Lifting
_____Poor Housekeeping
____Other: _____
____Defective Tools/Equipment
____Improper Procedures
____Improper PPE or PPE not used

RECOMMENDED CORRECTIVE ACTION:

_____

_____

Was Post-Accident Drug Test administered? Yes ☐ No ☐ Name of Hospital/Urgent Care Facility: _____

_____

If YES ~Location: _____

If NO ~Why? _____

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Person Completing Report: _____ Date: _____

CHEROKEE COUNTY WORKERS' COMPENSATION AUTHORIZATION FOR TREATMENT

Employer: CHEROKEE COUNTY BOARD OF COMMISSIONERS

Employee Name: _____

Department: _____ **Date of Injury:_____**

Drug Testing Required: Yes **Type of Test: ☐ 10 Panel (non DOT)**
☐ 5 Panel (DOT only)

Employer Authorization for Treatment:

_____ **Title:_____**
Name (print)

_____ **_____** **_____**
Signature **Date** **Title**

Employer Contact Information: **Robert Alford – Email:ralford@cherokeega.com**
People Resources Manager
Cherokee County BOC
1130 Bluffs Parkway
Canton, GA 30114
Office: 678-493-6019 ~ Cell 770-547-9293
Fax: 678-493-6017

Workers' Compensation Billing Information:
York Risk Services Group
P.O Box 183188
Columbus, OH 43218
1-877-366-9413
Local Adjuster ~667-260-5054

*PLEASE GIVE TO MEDICAL PROVIDER

YORK

Physician's Report / Pharmacy Guide

MAILING ADDRESS: P.O. Box 13188 Columbus, OH 43218
877-366-9413 www.yorkrsg.com

EMPLOYER: Please complete the top section and give to the injured employee to take to his or her authorized treating physician. If you already have transitional duty job descriptions available, please attach a copy for the treating physician's review.

Name of Employee/Patient: **Last:** _____ **First:** _____

Date of Injury: _____

Name of Employer / Company: _____

Employer Signature: _____ Name of Doctor Chosen: _____

EMPLOYEE: Please take this form with you to an authorized treating physician. Please have the physician complete the middle section and return this immediately to your employer. The bottom section is for you to show the pharmacist should you need to have any prescriptions filled as prescribed by your authorized treating physician for this work related injury.

AUTHORIZED PHYSICIAN, PLEASE COMPLETE

Diagnosis: _____

A post accident drug test **has** been completed ☐ or ☐ **has not** been completed (check one)

In accordance with this patient's physical capability, check all that apply:

- ☐ May resume work immediately with no restrictions
- ☐ May resume work immediately with the following restrictions:
  - ☐ Sedentary work (sitting, occasional walking, standing, lifting less than 10 pounds)
  - ☐ Light work (lifting less than 20 pounds)
  - ☐ Medium work (lifting less than 50 pounds)
  - ☐ Heavy work (lifting less than 100 pounds)
  - ☐ Normal shift
  - ☐ Limited hours per day: ☐ 2 hours; ☐ 4 hours; ☐ 6 hours
  - ☐ Other: _____

- ☐ Repetitive Motion Restrictions (specific to hand/arm injuries):

Frequency	Left	Right	Both
No Use	☐	☐	☐
Occasional <33% of time	☐	☐	☐
Frequent 34-66% of time	☐	☐	☐
Regular 67-100% of time	☐	☐	☐

- ☐ Patient may return to work at full duty on (date): _____
- ☐ Patient has a return appointment on (date): _____ at (time) _____

Please indicate any referrals that are required: _____

Physician's Signature	**Date**	**Physician's Name (type or print)**

Contact York Risk's Claim Department at 877-366-9413 for authorization for the referral.

PHARMACIST: Process all prescriptions through ***Optum*** for this patient. Contact ***Optum*** at (800) 547-3330 to establish eligibility.

DO NOT CHARGE THE PATIENT FOR THE PRESCRIPTION

Walgreens	Leader Drug Stores	King Soopers	Food Lion	Pamida Pharmacy	Medicine Chest Pharmacies
CVS	K-Mart	Medicap Pharmacies	Dillon Pharmacies	Wegmans	Ross Park Pharmacy
Rite Aid	Ahold	Fred's Pharmacy	Life Check	Kinney Drugs	Northeast Pharmacy Services
Wal-Mart	The Medicine Shoppe	Brookshire's	United Supermarkets	Bioscrip	Brookshire Brothers Food & Pharmacy
Giant Eagle Pharmacies	Family Care	Albertsons/Sav-On	Smith's Pharmacy	Spartan Stores	OPTUM® Please call 800.547.3330 for additional participating pharmacies.
Kroger	Long's Drug Stores	Raley's	The Vons Companies	U Save Pharmacy	
Meijer	Bashas	Hannaford Brothers	Sav-Mor Drug Stores	Randall's Food & Drug	
Costco	Harris Teeter	Hy-Vee	Pavilion Plaza Pharmacy	Foodarama Supermarkets	
Publix Super Markets	Kerr Drug	Ingles Markets	Kash N' Karry	Unity Pharmacies	
Albertsons	Winn-Dixie Stores	Aurora Pharmacy	Supervalu	City Market	
Farm Fresh	Major Value	True Care	Perlmart	Thrifty White	
Access Health	RxPride	Save Mart Supermarkets	JH Harvey	Super D Drugs	Tom Thumb Randall's Food & Drug
Target	Safeway Pharmacies	Shopko Stores	Bi-Lo Pharmacy	K-VAT-T Food Stores	Pharmacy Express

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, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-888-764-1284 or visit tmesys.com.

Questions? Need Help?

1-888-764-1284

OPTUM YORK

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

York Risk Services Group
CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

DISTRIBUTED BY (SIGNATURE) DATE

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: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-888-764-1284

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

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.

tmesys®

PART 3

Resource Information

ACCIDENT WITNESS STATEMENT

TO BE COMPLETED BY THE WITNESS ONLY!

Injured Employees Name: _____

Witness Name: _____ **Department: _____**

Date of Accident: _____ **Location: _____**

Describe fully how accident occurred:

_____
_____
_____

Describe Injury Sustained (be specific):

_____
_____

Recommendations on how to prevent this accident from occurring?

_____
_____

The above is factual to the best of my knowledge:

_____ _____
Name (Print) **Date**

_____
Signature

EXPOSURE INCIDENT INVESTIGATION REPORT

Name of Employee: _____
(Last) (First)

Department: _____

Date of Incident: ____/____/_____ **Time of Incident:** _____: _____ ☐ **AM** ☐ **PM**

Location of Incident: _____

Source of Exposure: __ **Blood Borne** __**Skin Contact** __**Airborne** __**Other**

Circumstances (work being performed, etc.):

_____
_____
_____

Cause of Incident ~ (accident, equipment malfunction, etc.):

_____
_____

Personal Protective Equipment Being Used:

_____
_____

Actions Taken: (decontamination, clean-up, reporting, etc.)

_____
_____

Recommendation for Remedial Action:

_____
_____
_____

_____ _____
Employee Signature **Date**

_____ _____
Signature of Person Completing Report **Date**

INFORMATION FOR DENTAL RELATED INJURIES

If an employee suffers a job related dental injury, they may choose to see their own dentist. Please follow the procedures for Workers' Compensation medical injuries and utilize the authorization treatment form located in the Workers' Compensation packet.

BILLING INFO **:**

Workers' Compensation Third Party Administrator, York Risk Services Group˜ Local Adjuster ˜ Phone 667-260-5054 ˜ Mailing address: York Risk Services Group P.O. Box 183188, Columbus, OH 43218

CLAIM NUMBER: If you do not have a claim number, ask the Dentist to contact:

Robert Alford: People Resources Manager:
Office ˜ 678-493-6019 ˜ C e l l ˜ 770-547-9293
FAX: 678-493-6017 ˜ Email: ralford@cherokeega.com