WORK-RELATED INJURIES

INSTRUCTIONS AND FORMS

All forms are fill-in PDF forms. The boxes where information is needed can be typed in and printed out or printed out and handwritten in ink.

The injured employee must notify the supervisor as soon as possible of the injury.

Injuries that are severe or require immediate medical attention should call 911 or go to the nearest emergency room. These include (but are not limited to)…severe cuts and lacerations, broken bones, head injuries, severe burns, eye injuries, chest pain, breathing difficulties and severe allergic reactions.

Injuries that are moderate or non-urgent may not require immediate emergency care but should still be assessed by a healthcare professional. The supervisor will complete the following (4) forms.

1. **Medical Authorization Form**. This form is for Ascension Occupational Medicine locations and will show the service they need to provide to the employee. This is the same form used for the pre-employment drug testing, but it is filled in with different information. Use the form included in this packet. The back of the authorization page will show the preferred medical providers to treat the injury. Please notice the service hours at the different facilities will vary.

   Fill in the following boxes: Employee Name, Dept, Authorization Signature and Date. Go down to the Workmans Compensation Box on the left and fill in Date of Injury, Location of Injury, and make sure the Carrier is shown as being Davies. The other service boxes should be blank unless the employee needs another service performed.

☐**GIVE A COMPLETED FORM TO THE INJURED EMPLOYEE** to turn in at the selected medical facility

☐ **SEND A COMPLETED FORM TO Teri Lukeman** at tlukeman@vanderburghgov.org **and Paula Hurt** at pahurt@vanderburghgov.org

2. **Workers' Compensation Information Card**. The employee will show this card to any medical facility where they receive care for the injury. In some cases, the original facility may refer them to another facility(s), each facility used must have this correct billing information, or the employee may be billed for the services provided during treatment.

Fill in the following boxes: Department, Employee Name and Date of Injury

☐ **GIVE A COMPLETED FORM TO THE INJURED EMPLOYEE** to turn in at the selected medical facility(s)

3. **First Fill Prescription Card** (Mitchell Script Advisor)**.** If medication is prescribed for the injury, the employee will give this completed form to the participating pharmacy along with the prescription. A maximum 10-day supply of medication(s) can be dispensed with this card. An RX card will be mailed for future prescriptions. Participating pharmacies currently include Walgreens, CVS, Nation's Medicines and Walmart, Costco and Sam's Club Pharmacies. This can change at any time without notice. There is a toll-free number and a website on the form if they would need to locate a participating pharmacy.

   Fill in the following boxes: Employee's Name and Member ID# using the date of injury+date of birth format (mmddyymmddyy)

   ☐ **GIVE A COMPLETED FORM TO THE INJURED EMPLOYEE** to turn in at the participating pharmacy along with the prescription

The supervisor must COMPLETE FORM 4 for all reported work-related injuries, regardless of whether the employee seeks medical care.

4. **First Report of Injury (FROI)**. This form provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. FROI's being turned into our office on a timely basis is vital to ensure all necessary medical treatments are being approved by our insurance (example: MRIs). Our insurance company cannot do this without a completed FROI.

   There are 3 sections that need to be completed on this form. General instructions are on the back of this form.

   Employee Information Section
   - Make sure all the boxes are completed unless it says SKIP.

   Employer Information Section
   - Make sure to enter your department in the first box.
   - *Often Overlooked:* If the injury occurred off-property, you must put the **full address of where the injury occurred** in the allocated space.

Occurrence/Treatment Information Section

- All boxes in this area may not pertain to the circumstances of your particular injury (example: date of death). Just enter N/A in those boxes.
- Make sure an option is selected in the Initial Treatment box.
- If the employee was seen by a medical facility, make sure the name of the facility's location and address are shown in the box.
- Witnesses are important. Don't leave this information off if someone was a witness to the work-related injury.

☐ **PLEASE RETURN THIS COMPLETED FORM TO OUR OFFICE AS SOON AS POSSIBLE—SEND A COMPLETED FORM TO Teri Lukeman** at tlukeman@vanderburghgov.org **and Paula Hurt** at pahurt@vanderburghgov.org

ALSO IMPORTANT:

- Please get any documentation to us that was given or mailed to the employee by a medical facility at any time during treatment. This includes, but is not limited to, visit summary sheets, follow-up appointments, billing and letters and/or claims from the medical facility, etc.

Always call or email if you have any questions.

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