Friendswood Independent School District
302 Laurel, Friendswood Texas 77546
Phone: 281-482-1267 Fax: 281-996-2606

Workers' Compensation Information

The following information must be completed for all Work Comp injuries regardless of whether medical attention is needed:

1. First Report of Injury – must be completed online immediately by campus/department designated personnel. To fill out a First Report of Injury go to www.tasbrmf.org

The following must be completed if seeking medical treatment:

2. Employer's Authorization for Examination or Treatment – completed by designated personnel and given to employee **immediately** to take with them to the treating facility
3. Employee Acknowledgment of the Alliance Direct Contracting Program – Must be signed by employee and returned **immediately** to the benefits office
4. HELIOS – tmesys Prescription Card - Completed by campus/department designated personnel and given to employee **immediately** before employee leaves for treatment for initial prescription fill at no cost to the employee

This form must be complete if injury results in an absence from duty:

5. Election of Leave Benefits with Workers' Compensation – Must be completed, signed by the employee and sent **immediately** to the benefits office

This report will be completed by a treating physician:

6. Texas Workers' Compensation Work Status Report – Must be completed each time the employee is seen by a physician/clinic. Please see instructions below based on box selected by physician
    a. Medical Treatment Only – before returning to work this must be completed by the attending physician releasing the employee to work
    b. Medical Treatment and Absence from Duty – this form must be completed at each visit to the attending physician detailing any restrictions and when released to full duty
    c. This form must be given to the benefits office **immediately via fax or email**

It is the employee's responsibility to communicate with the benefits coordinator immediately following every doctor's visit.

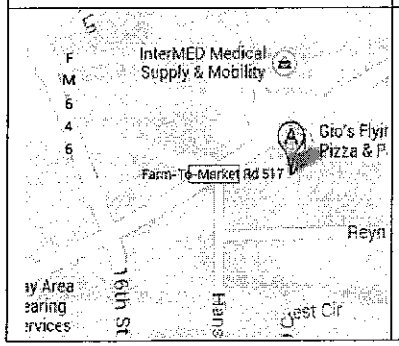
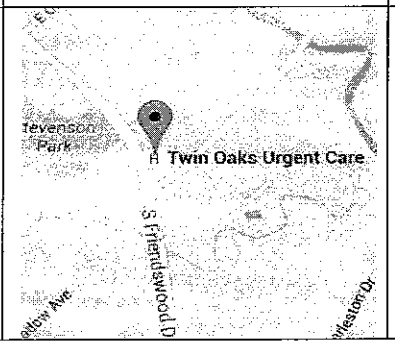
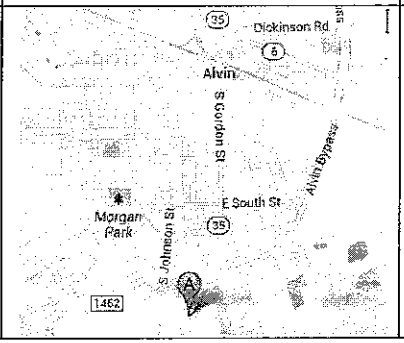
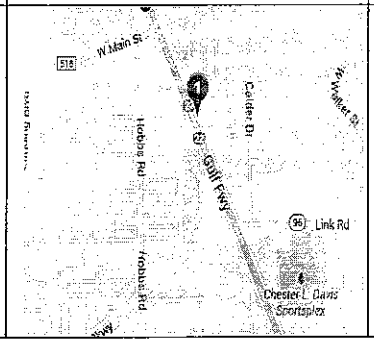
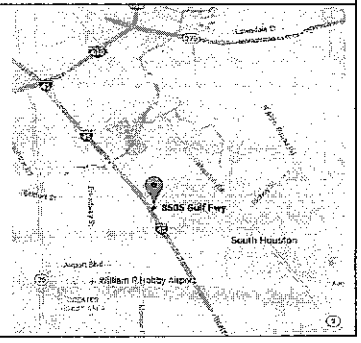
For Employee Information (give these copies to the employee):

7. Employee Notice of Alliance Requirements
8. Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System

For any questions relating to Workers' Compensation please contact Tara Langston, Benefits Coordinator at 281-482-1267 or tlangston@fisdk12.net

Friendswood Independent School District
302 Laurel, Friendswood Texas 77546
Phone: 281-482-1267 Fax: 281-996-2606

Friendswood ISD has chosen the Political Subdivision Workers' Compensation Alliance (the Alliance) to manage the health care and treatment you may receive if you are injured at work. For emergencies, you may go to the nearest emergency room. Otherwise, you must choose a treating doctor from the Alliance Provider list. The following are the closest and most convenient clinics to our campuses:

WellNow Health/ **St. Elizabeth Urgent Care** 676 F.M. 517 W Dickinson, TX 77539 409-572-2535	**Twin Oaks Urgent Care** 1111 S. Friendswood Dr. Suite 105 Friendswood, TX 77546 832-569-4390	**Affinity Immediate Care** 3128 Hwy 35 South Alvin, TX 7511 281-886-8964	**Calder Urgent Care** 1108 Gulf Fwy, Suite 230 League City, TX 77573 281-557-4404	**Concerta-Houston Hobby** 8505 Gulf Freeway, Suite F Houston, TX 77017 713-944-4442
Hours: M-F 8 am – 7 pm Sat 9 am – 2 pm	Hours: M-F 8 am – 8 pm Sat & Sun 9 am – 5 pm	Hours: M-F 8 am – 8 pm Sat & Sun 9 am – 5 pm	Hours: M-F 9 am – 7 pm Sat 9 am – 3 pm Sun & Holiday 10am – 2pm	Hours: M-F 8 am – 5 pm
Additional Information: On site digital X-ray & lab	Additional Information: On site X-ray & lab	Additional Information: On site digital X-ray & lab	Additional Information: X-rays on site	Additional Information: On site X-rays & lab
				

A full list of the Alliance providers can be found at www.pswca.org.
You may contact your adjuster at the TASB Risk Management Fund at 800- 482-7276.

INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-001)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Section 409.005, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM-001 Rev. 10/05 to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Section 409.006. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.** The Division's Health and Safety will use data from this report for the Job Safety Information System established in Section 411.032 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2,7,8:	Section 402.082, Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
Item 4:	If no home phone, please provide a phone number where the employee can be reached.
Items 5,15,17, 26,29,30:	Enter data in month, day, year format. Example: 08-13-54.
Item 18:	List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.
Item 19:	List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
Item 20:	Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
Item 22:	State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.
Item 24:	List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.
Items 32,33:	Enter date in month-year format. Example: 02-56.
Item 37:	Enter the number of days or hours that make up a full work week for your employees.
Item 45:	Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.
Item 46:	For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☐ M ☐

3. Social Security Number - -

4. Home Phone ( )

5. Date of Birth (m-d-y) - -

6. Does the Employee Speak English? If No, Specify Language
YES ☐ NO ☐

7. Race White ☐ Black ☐ Asian ☐

8. Ethnicity Hispanic ☐ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status
Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name

14. Doctor's Mailing Address (Street or P.O.Box)

City State Zip Code

15. Date of Injury (m-d-y) - -

16. Time of Injury : am ☐ pm ☐

17. Date Lost Time Began (m-d-y) - -

18. Nature of Injury*

19. Part of Body Injured or Exposed*

20. How and Why Injury/Illness Occurred*

21. Was employee doing his regular job? YES ☐ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site

Street or P.O. Box County

City State Zip Code

24. Cause of Injury(fall, tool, machine, etc.)*

25. List Witnesses

26. Return to work date/or expected (m-d-y) - -

27. Did employee die? YES ☐ NO ☐

28. Supervisor's Name

29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y) - -

31. Was employee hired or recruited in Texas? YES ☐ NO ☐

32. Length of Service in Current Position Months _____ Years _____

33. Length of Service in Occupation Months _____ Years _____

34. Employee Payroll Classification Code

35. Occupation of Injured Worker

36. Rate of Pay at this Job $_____Hourly $_____Weekly

37. Full Work Week is: _____ Hours _____ Days

38. Last Paycheck was: $_____ for ___ Hours or _____ Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form

41. Name of Business

42. Business Mailing Address and Telephone Number
Street or P.O. Box Telephone ( )

City State Zip Code

43. Business Location (If different from mailing address)
Number and Street

City State Zip Code

44. Federal Tax Identification Number

45. Primary North American Industry Classification System Code:(6 digit)

46. Specific NAICS Code (6 digit)

47. Texas Comptroller Taxpayer No.

48. Workers' Compensation Insurance Company

49. Policy Number

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____

Friendswood Independent School District

302 Laurel, Friendswood, Texas 77546

Phone: 281-482-1267 Fax: 281-996-2606

Verification of Employment for a Reported Workers' Compensation Injury or Illness

Employee Name _____ Date of Injury _____

Date of Birth _____ SSN _____

Reported Work Related Injury or Illness _____

Post Accident Drug Testing Requested _____

(Drug testing is directed by only the Employer(designated personnel) and must be billed separately and directly to Friendswood ISD)

Friendswood ISD's workers' compensation coverage provider is the Texas Association of School Boards Risk Management Fund which is a member of the Political Subdivision Workers' Compensation Alliance (the Alliance.) For emergencies, an injured employee may go to the nearest emergency room. Otherwise, all other treatment must be from an Alliance Provider listed at www.pswca.org.

Please submit all claim and medical billing information to:

TASB Risk Management Fund
PO Box 2010
Austin, TX 78768-2010
Phone: (800) 482-7276
Fax: (800) 580-6720
Pre-Authorization
Phone: (800) 482-7276 ext. 6654
Fax: (888) 777-8272

Authorized by _____ Title _____

Phone _____ Date _____

District Contact : Tara Langston, Benefits Coordinator
281-482-1267 x 6605
tlangston@fisdk12.net
direct fax 281-996-2606

EMPLOYEE ACKNOWLEDGMENT OF THE ALLIANCE DIRECT CONTRACTING PROGRAM

I have received information that tells me how to get health care under my employer's workers' compensation coverage. If I am hurt on the job and live in a service area described in this information, I understand that:

1. I must choose a treating doctor from the Alliance list of doctors designated as treating doctors.
2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go to any licensed medical professional within the United States.
3. Even though my treating doctor should refer me to a specialist of providers contracted with the Alliance, I understand that I need to verify that the referral doctor is a member of the Alliance provider panel.
4. The Texas Association of School Boards Risk Management Fund will pay the treating doctor and other Alliance providers for all health care related to my compensable injury.
5. I understand that my medical and/or income benefits may be disputed if I receive health care from a provider other than an Alliance provider without prior approval from the Fund.
6. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.
7. If I want to change doctors after my first choice, I can do so within the first 60 days of starting treatment, and I can only choose from the Alliance list of providers. A third choice requires approval from my adjuster.

_____ ____/____/____

Signature Date

_____

Printed Name

I live at: _____

Street Address

_____, _____ _____

City State Zip Code

Name of Employer: _____

Name of Direct Contracting Program: Political Subdivision Workers' Compensation Alliance (the Alliance)

Direct contracting service areas are subject to change. To locate a treating doctor within your area, visit the PSWCA web site at www.pswca.org or call your adjuster at 800-482-7276.

To be completed by the employer only

Please indicate whether this is the:

☐ Initial Employee Notification
☐ Injury Notification (Date of Injury: ____/____/____)

DO NOT RETURN THIS FORM TO THE TASB RISK MANAGEMENT FUND UNLESS REQUESTED.

Election of Leave Benefits with Workers' Compensation

Name _____ Employee Number _____

Position _____ Department/Campus_____

This employee is absent from duty because of a job-related illness or injury beginning on _____ (date of first absence attributable to illness or injury). If eligible, workers' compensation insurance may begin paying a percentage of the employee's current wages on the eighth day of absence from duty if an extended absence is required.

_____ _____

District Authorized Signature Date

Employee Choice:

I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I also understand that the district will continue to pay its contribution toward the cost of my group health insurance coverage (if applicable) as long as I am on **paid** leave and/or family and medical leave (FMLA). I further understand that I will be responsible for paying all health insurance premiums if I am on **unpaid** leave that is not FMLA leave. I choose the following option:

☐ I choose to use only _____ days of available paid leave at this time.

☐ I choose to use all available paid leave. I understand that I will not receive workers' compensation weekly income benefits until I have exhausted all of my paid leave or to eth extent that paid leave does not equal my pre-illness or pre-injury wage.

☐ I choose **not** to use any available paid leave at this time. I understand that I will not receive any regular salary payments from Friendswood Independent School District while receiving weekly income benefits under workers' compensation. No available paid leave will be deducted from my leave balance. I further understand that by selecting this option, I will only receive workers' compensation wage benefits for any absences resulting from my work related illness injury, unless and until I communicate to the district a change in my decision.

Employee signature _____ Date _____

For Claims Reporting Purposes Only:	
For all employees: Amount of leave paid to employee: $ ____.__ Daily rate: $_____ Period of payment from __/__/__ through __/__/__ for ____days **or**____weeks	For hourly employee only: Hourly rate: $_____.___ Number of hours paid:_____

OPTUM®

TASB RISK MANAGEMENT FUND

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 TASB Risk Management Fund. 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 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

TASB RISK MANAGEMENT FUND

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

TASB Risk Management Fund
CARRIER/TPA EMPLOYER

INJURED WORKER NAME

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

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. This card is not valid for compound medications.

Tmesys Pharmacy Help Desk
1-800-964-2531

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

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®

IMP14-1614-167

OPTUM®

TASB RISK MANAGEMENT FUND

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para TASB Risk Management Fund. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM®

TASB RISK MANAGEMENT FUND

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

TASB Risk Management Fund
PORTADORA EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite 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. This card is not valid for compound medications.

Tmesys Pharmacy Help Desk
1-800-964-2531

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

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-167

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(800)-252-7031.

Empleado - Es necesario que reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que se lesionó si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte de la División de Compensación para Trabajadores, y también puede tener derecho a ciertos beneficios médicos y monetarios. Para mayor información comuníquese con la oficina local de la División al teléfono 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

PART I: GENERAL INFORMATION

5. Doctor's Name and Degree		(for transmission purposes only)	Date Being Sent
1. Injured Employee's Name	6. Clinic/Facility Name	9. Employer's Name	
2. Date of Injury / 3. Social Security Number (last 4) XXX-XX-	7. Clinic/Facility/Doctor Phone & Fax	10. Employer's Fax # or Email Address (if known)	
4. Employee's Description of Injury/Accident	8. Clinic/Facility/Doctor Address (street address)	11. Insurance Carrier	
	City State Zip	12. Carrier's Fax # or Email Address (if known)	

PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE)

13. The injured employee's medical condition resulting from the workers' compensation injury:

☐ (a) will allow the employee **to return to work** as of _____ (date) **without restrictions**.

☐ (b) will allow the employee **to return to work** as of _____ (date) **with the restrictions identified in PART III**, which are expected to last through _____ (date).

☐ (c) has prevented and still prevents the employee **from returning to work** as of _____ (date) and is expected to continue through _____ (date).

The following describes how this injury **prevents the employee from returning to work:**

PART III: ACTIVITY RESTRICTIONS* (ONLY COMPLETE IF BOX 13(b) IS CHECKED)

14. POSTURE RESTRICTIONS (if any):		17. MOTION RESTRICTIONS (if any):		19. MISC. RESTRICTIONS (if any):
Max Hours per day: 0 2 4 6 8	Other	Max Hours per day: 0 2 4 6 8	Other	☐ Max hours per day of work: _____
Standing ☐☐☐☐☐		Walking ☐☐☐☐☐		☐ Sit/Stretch breaks of _____ per _____
Sitting ☐☐☐☐☐		Climbing stairs/ladders ☐☐☐☐☐		☐ Must wear splint/cast at work
Kneeling/Squatting ☐☐☐☐☐		Grasping/Squeezing ☐☐☐☐☐		☐ Must use crutches at all times
Bending/Stooping ☐☐☐☐☐		Wrist flexion/extension ☐☐☐☐☐		☐ No driving/operating heavy equipment
Pushing/Pulling ☐☐☐☐☐		Reaching ☐☐☐☐☐		☐ Can only drive automatic transmission
Twisting ☐☐☐☐☐		Overhead Reaching ☐☐☐☐☐		☐ No work / _____ hours/day work: ☐ in extreme hot/cold environments ☐ at heights or on scaffolding
Other: ☐☐☐☐☐		Keyboarding ☐☐☐☐☐		☐ Must keep _____ ☐ elevated ☐ clean & dry

15. RESTRICTIONS SPECIFIC TO (if applicable):

☐ Left Hand/Wrist ☐ Left Leg
☐ Right Hand/Wrist ☐ Right Leg
☐ Left Arm ☐ Back
☐ Right Arm ☐ Left Foot/Ankle
☐ Neck ☐ Right Foot/Ankle

Other:

16. OTHER RESTRICTIONS (if any):

Other:

18. LIFT/CARRY RESTRICTIONS (if any):

☐ May not lift/carry objects more than _____ lbs. for more than _____ hours per day
☐ May not perform any lifting/carrying

Other:

☐ No skin contact with: _____
☐ Dressing changes necessary at work
☐ No running

20. MEDICATION RESTRICTIONS (if any):

☐ Must take prescription medication(s)
☐ Advised to take over-the-counter meds
☐ Medication may make drowsy (possible safety/driving issues)

* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work.

PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

21. Work Injury Diagnosis Information:

22. Expected Follow-up Services Include:

☐ Evaluation by the treating doctor on _____ (date) at _____ : _____ am/pm
☐ Referral to/Consult with _____ on _____ (date) at _____ : _____ am/pm
☐ Physical medicine _____ X per week for _____ weeks starting on _____ (date) at _____ : _____ am/pm
☐ Special studies (list): _____ on _____ (date) at _____ : _____ am/pm
☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date / Time of Visit	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type:	Role of Doctor:	
Discharge Time			☐ Initial ☐ Follow-up	☐ Designated doctor ☐ Treating doctor ☐ Referral doctor ☐ Consulting doctor	☐ Carrier-selected RME ☐ DWC-selected RME ☐ Other doctor

EMPLOYEE NOTICE OF ALLIANCE REQUIREMENTS

Important Contact Information
To locate a provider, go to www.pswca.org.
To contact your adjuster at the TASB Risk Management Fund, visit www.tasbrmf.org or call (800) 482-7276.

Information, Instructions, Rights, and Obligations

If you are injured at work, tell your supervisor or employer immediately. The information in this notice will help you to seek medical treatment for your injury. Your employer will also help with any questions about how to get treatment. You may also contact your adjuster at the TASB Risk Management Fund (the Fund) for any questions about treatment for a work related injury. The Fund is your employer's workers' compensation coverage provider and they are working with your employer to ensure you receive timely and appropriate health care. The goal is to return you to work as soon as it is safe to do so.

- **How do I choose a treating doctor?**
  If you are hurt at work **and** you live in the Alliance service area, you are required to choose a treating doctor from the provider list. This is required for you to receive coverage of healthcare costs for your work related injury. A provider listing is available through the Alliance website at www.pswca.org and a link to that site is also contained on the Fund's website at www.tasbrmf.org. It identifies providers who are taking new patients.

  If your treating doctor leaves the Alliance, we will tell you in writing. You will have the right to choose another treating doctor from the list of Alliance doctors. If your doctor leaves the Alliance and you have a life threatening or acute condition for which a disruption of care would be harmful to you, your doctor may request that you treat with him or her for an extra **90 days.**

- **What if I live outside the service area?**
  If you believe you live outside of the service area, you may request a service area review by calling your adjuster.

- **How do I change treating doctors?**
  Within the first 60 days of beginning treatment, if you become dissatisfied with your first choice of a treating doctor, you can select an alternate treating doctor from the list of Alliance treating doctors in your service area. The Fund will not deny a choice of an alternate treating doctor. **However, before you can change treating doctors a second time, you must obtain permission from your adjuster.**

- **How are treating doctor referrals handled?**
  Referrals for health care services that you or your doctor request will be made available on a timely basis as required by your medical condition. Referrals will be made **no later than 21 days** after the request. Your doctor should refer you to another Alliance provider unless it becomes medically necessary to make a referral outside of the Alliance. You do not have to get a referral if you are in need of emergency care.

- **Who pays for the healthcare?**
  Alliance providers have agreed to seek payment from the Fund for your health care. They should not request payment from you. If you obtain health care from a doctor who is not in the Alliance without prior approval from your adjuster, you may have to pay for the cost of that care and your income benefits may be disputed. You may treat with medical providers that are **not contracted** with the Alliance only if one of the following situations occurs:

  - Emergencies: You should go to the nearest hospital or emergency care facility.
  - You do not live within an Alliance service area.
  - Your treating doctor refers you to a provider or facility outside of the Alliance. This referral must be approved by your adjuster.

EMPLOYEE NOTICE OF ALLIANCE REQUIREMENTS – PAGE 2

How to File a Complaint

You have the right to file a complaint with the Alliance. You may do this if you are dissatisfied with any aspect of direct contract program operations. This includes a complaint about the program and/or your Alliance doctor. It may also be a general complaint about the Alliance. A complainant can notify the Alliance Grievance Coordinator of a complaint by phone, from the Alliance website www.pswca.org or in writing via mail or fax. Complaints should be forwarded to:

PSWCA (The Alliance)
Attention: Grievance Coordinator
P.O. Box 763
Austin, TX 78767-0763
866-997-7922

A complaint must be filed with the program grievance coordinator **no later than 90 days from the date the issue occurred**. Texas law does not permit the Alliance to retaliate against you if you file a complaint against the program. Nor can the Alliance retaliate if you appeal the decision of the program. The law does not permit the Alliance to retaliate against your treating doctor if he or she files a complaint against the program or appeals the decision of the program on your behalf.

What to do when you are injured on the job

If you are injured while on the job, tell your employer as soon as possible. A list of Alliance treating doctors in your service area may be available from your employer. A complete list of Alliance treating doctors is also available online at www.pswca.org. Or, you may contact us directly at the following address and/or toll-free telephone number:

TASB Risk Management Fund
P.O. Box 2010
Austin, TX 78768
(800) 482-7276

In case of an emergency…

If you are hurt at work and it is a life threatening emergency, you should go to the nearest emergency room. If you are injured at work after normal business hours or while working outside your service area, you should go to the nearest care facility. After you receive emergency care, you may need ongoing care. You will need to select a treating doctor from the Alliance provider list. This list is available online at www.pswca.org. If you do not have internet access call (800) 482-7276 or contact your employer for a list. The doctor you choose will oversee the care you receive for your work related injury. Except for emergency care you must obtain all health care and specialist referrals through your treating doctor.

Emergency care does not need to be approved in advance. "Medical emergency" is defined in Texas laws. It is a medical condition that comes up suddenly with acute symptoms that are severe enough that a reasonable person would believe that you need immediate care or you would be harmed. That harm would include your health or bodily functions being in danger or a loss of function of any body organ or part.

EMPLOYEE NOTICE OF ALLIANCE REQUIREMENTS – PAGE 3

Non-emergency care…
Report your injury to your employer as soon as you can. Select a treating doctor from the Alliance provider list. This list is available online at www.pswca.org. If you do not have internet access, call 800- 482-7276 or contact your employer for a list.

Treatments Requiring Advance Approval

Certain treatments or services prescribed by your doctor need to be approved in advance. Your doctor is required to request approval from the TASB Risk Management Fund before the specific treatment or service is provided. For example, you may need to stay more days in the hospital than what was first approved. If so, the added treatment must be approved in advance.

The following non-emergency healthcare treatment requests must be approved in advance:

Inpatient hospital admissions
Outpatient Surgical or ambulatory surgical services
Spinal Surgery
All non-exempted work hardening
All non-exempted work conditioning
Physical or occupational therapy except for the first twelve (12) visits if those visits were done within the first 6 months immediately following date of injury or date of surgery
Any investigational or experimental service
Psychological testing exceeding 3 hours with no more than four tests, such as MMPI2, BDI, BAI, P-3
Repeat psychological testing
Psychotherapy and cognitive/behavioral therapy greater than 6 visits, repeat psychological interviews and biofeedback
Repeat diagnostic studies greater than $350.
All durable medical equipment (DME) in excess of $500
Chronic pain management and interdisciplinary pain rehabilitation
Drugs not included in the TDI Division of Workers' Compensation Formulary
All narcotic medications dispensed greater than 60 days
Any treatment or service that exceeds the Official Disability Guidelines.

The number your doctor must call to request one of these treatments is 800-482-7276, ext. 6654. If a treatment or service request is denied, we will tell you in writing. This written notice will have information about your right to request a reconsideration or appeal of the denied treatment. It will also tell you about your right to request review by an Independent Review Organization through the Texas Department of Insurance.

Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System

As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel. This assistance is offered at local offices across the state. These local offices also provide other workers' compensation system services from the Texas Department of Insurance. This is the state agency that administers the system through the Division of Workers' Compensation.

You can contact the Office of Injured Employee Counsel by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). More information is available on the Internet at: www.oiec.state.tx.us.

You can contact the Division of Workers' Compensation by calling the toll-free telephone number 1-800-252-7031. More information about the Division is available on the Internet at: www.tdi.state.tx.us/wc/indexwc.html.

Your Rights in the
Texas Workers' Compensation System

1. **You may have the right to receive benefits.**
   You may receive benefits regardless of who was at fault for your injury with certain exceptions, such as:
   - You were intoxicated at the time of the injury;
   - You injured yourself on purpose or while trying to injure someone else;
   - You were injured by another person for personal reasons;
   - You were injured by an act of God;
   - Your injury occurred during horseplay; or
   - Your injury occurred while voluntarily participating in an off-work activity.

2. **You have the right to receive medical care to treat your workplace injury or illness. There is no time limit for this medical care.**

3. **You have the right to choose your treating doctor. If you are in a Workers' Compensation Health Care Network, you can choose your doctor from the network's treating doctor list. If you are not in a network, you can choose a doctor from the Approved Doctor List kept by the Division of Workers' Compensation.**
   It is important to follow all the rules in the workers' compensation system. If you don't follow these rules, you may be held responsible for payment of medical bills.

4. **You have the right to hire an attorney at any time to help you with your claim.**

5. **You have the right to receive information and assistance from the Office of Injured Employee Counsel at no cost.**
   Staff is available to answer your questions and explain your rights and responsibilities by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432).

6. **You have the right to receive ombudsman assistance if you do not have an attorney and a dispute resolution proceeding about your claim has been scheduled.**
   An ombudsman is an employee of the Office of Injured Employee Counsel. Ombudsmen are trained in the field of workers' compensation and provide free assistance to injured employees without attorneys. Ombudsmen cannot sign documents for you, make decisions for you or give legal advice. Proceedings about your claim may include benefit review conferences (BRCs) or contested case hearings (CCHs). Proceedings are held at local field offices. At least one ombudsman is located in each local office.

7. **You have the right for your claim information to be kept confidential.**
   In most cases, the contents of your claim file cannot be obtained by others. Some parties have a right to know what is in your claim file, such as your employer or your employer's insurance carrier. Also, an employer that is considering hiring you may get limited information about your claim from the Division of Workers' Compensation.

(SEE REVERSE SIDE FOR RESPONSIBILITIES)

Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System

Your Responsibilities in the
Texas Workers' Compensation System

1. **You have the responsibility to tell your employer if you have been injured at work or in the scope of your employment.**
   You must tell your employer within 30 days of the date you were injured or first knew your injury or illness might be work related.

2. **You have the responsibility to know if you are in a Workers' Compensation Health Care Network ("network").**
   If you do not know whether you are in a network, ask the employer you worked for at the time of your injury. If you are in a network, you have the responsibility to follow the network rules. Your employer must give you a copy of the Texas Department of Insurance network rules. Read the rules carefully. If there is something you do not understand, ask your employer or call the Office of Injured Employee Counsel.
   If you would like to file a complaint about a network, call the Consumer Help Line at 1-800-252-3439.
   Or file a complaint on the Internet at: www.tdi.state.tx.us/consumer/complfrm.html#wc

3. **You have the responsibility to tell your doctor how you were injured and whether the injury is work-related.**

4. **You have the responsibility to send a completed claim form (DWC-41) to the Division of Workers' Compensation. You have one year to send the form after you were injured or first knew that your illness might be work related.**
   Send the completed DWC-41 form even if you already are receiving benefits. You may lose your right to benefits if you do not send the completed claim form to the Division of Workers' Compensation.
   Call toll-free 1-800-252-7031 or 1-866-393-6432 for a copy of the DWC-41 form.

5. **You have the responsibility to provide your current address, telephone number, and employer information to the Division of Workers' Compensation and the insurance carrier.**

6. **You have the responsibility to tell the Division of Workers' Compensation and the insurance carrier any time there is a change in your employment status or wages. Examples include:**
   - You stop working because of your injury;
   - You start working; or
   - You are offered a job.

(SEE REVERSE SIDE FOR RIGHTS)

Contact the Office of Injured Employee Counsel by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). More information is available on the Internet at: www.oiec.state.tx.us.

Contact the Division of Workers' Compensation by calling the toll-free telephone number 1-800-252-7031. More information about the Division is available on the Internet at: www.tdi.state.tx.us/wc/indexwc.html.

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