CITY OF DUNN
WORKER'S COMPENSATION PROCEDURES

Pursuant to North Carolina General Statute 97-1 all employers with three or more employees are required to obtain insurance to cover all job related injuries and/or occupational diseases.

The purpose of the worker's compensation act is to cover employees who suffer an injury by accident or an occupational disease. All injuries must arise out of and in the course and scope of the covered employment to be considered.

PROCEDURES

1. When an accident is reported, the Supervisor or Department Head will complete an **Employee Injury Report**. The injured employee will review the completed report for accuracy and sign it.

2. Have the injured employee sign the **Authorization for Release of Information.**

3. Provide the injured employee with their **<u>Post-Incident Medical Treatment Kit</u>** which includes:
   Letter of Introduction to the Physician
   Physician's Report/Pharmacy Guide
   Optum Instant Access Card – Temporary Pharmacy Card

4. The Supervisor or Department Head should complete the employer section of the **Physician's Report/Pharmacy Guide** and have the injured employee take this form with them to an authorized treating physician. The physician will complete the middle section.

5. If a prescription is required, the employee will need to take the **Optum Instant Access Card-Temporary Pharmacy Card** with them to a participating Optum pharmacy. The prescription will be filled with no "out of pocket" cost to the employee. Key Risk will be billed directly.

6. Supervisors or Department Heads should ***<u>immediately</u>*** forward these completed forms to Human Resources to be filed with the Industrial Commission:
   Employee Injury Report
   Physician's Report/Pharmacy Guide
   Authorization for Release of Information

7. All follow-up physician notes should also be forwarded to Human Resources.

MEDICAL FACILITIES

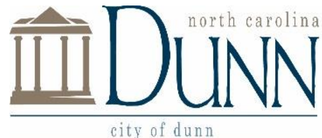
If non-emergency medical treatment is required, **ALL** employees are to go to the following medical facility:

Med-Fast Urgent Care	**Hours:**	**Mon–Tues–Wed–Fri**	**(9:00am – 5:30pm)**
605 W. Cumberland Street		**Thursday**	**(9:00am – 1:30pm)**
Dunn, NC 28334		**Saturday**	**(9:00am – 1:30pm)**
(910) 891-1391		**Sunday**	**(1:00pm – 3:30pm)**

FOR ALL EMERGENCIES AND LIFE THREATENING INJURIES, EMPLOYEE SHOULD GO DIRECTLY TO THE NEAREST EMERGENCY ROOM.

In the event that Med Fast in Dunn is closed, please send the employee to one of the following participating providers:

Med-Fast Urgent Care	Hours:	Mon-Tues-Thurs-Fri	(9:00am – 5:30pm)
602 S. Wall Street		Wednesday	(9:00am – 1:30pm)
Benson, NC 27521		Saturday & Sunday	(Closed)
(919) 894-3321			



CITY OF DUNN
EMPLOYEE INJURY REPORT

GENERAL INFORMATION

Name of Injured: ______________________________________ Date of Injury: ______________ Time: ______

Department: ___________________________ Job Title: ____

Date of Hire: _____________ Phone: _______________ Date Reported: _____________ Time Reported: ______

Supervisor: ____ Phone: ____________________________

Location of Accident: ____

NATURE OF INJURY

Describe, in detail, how the accident happened: ____

____

____

____

List any witnesses to the accident: ____ Phone: _____________

____ Phone: _____________

Was accident caused by employee's failure to use safety equipment? Yes ☐ No ☐

Was the employee following the City of Dunn Safety Policy? Yes ☐ No ☐

Type of Injury: _________________________________Body Part(s) Injured: _____________________________

LOST TIME

Was the employee seen by a physician? Yes ☐ No ☐ Name of Facility: _______________________________

Has the employee returned to work? Yes ☐ No ☐ If yes, give: Date: _________________ Time: _______

Is the employee released to full duty? Yes ☐ No ☐ *(Please attach Physician's Report / Pharmacy Guide)*

SIGNATURES

____ ________________________________

Employee Signature *Date*

____ ________________________________

Signature of Person Completing This Report *Date*

____ ________________________________

Supervisor / Department Head Signature *Date*

Authorization

The undersigned has filed a claim for workers compensation benefits (hereafter referred to as the "Claim"). The amount and type of information sought pursuant to this authorization will depend upon the nature of the Claim, but will be used solely to facilitate determination regarding validity of the Claim and the payment of benefits or the administration of the insurance program under which the Claim has been made. Authorizing the disclosure of information is voluntary, and acceptance of the Claim will not be conditioned upon signing this authorization. This authorization is subject to revocation at any time, except to the extent that any party has already acted in reliance upon it. Any revocation must be submitted in writing to Key Risk, P.O. Box 8000, Daphne, AL 36526-8000.

The undersigned authorizes the release of information and communication between his or her health care provider(s) (including, without limitation, medical laboratories, pharmacies, pharmacy benefit managers, and medical suppliers) and representatives of Key Risk Management Services/Berkley Insurance Company ("Key Risk").

This release of information applies to all applicable medical records, medical information, bodily fluid and tissue samples, and benefit payment information with respect to any illness, injury, medical history, consultation, prescription, treatment, or benefit, and copies of all applicable records thereof, which may be appropriate or necessary throughout the course of this Claim. This authorization shall specifically include, but shall not be limited to, medical records, medical information and benefit payment information pertaining to or relating to the treatment of Acquired Immune Deficiency Syndrome, HIV, mental illness, and drug or alcohol related problems.

The undersigned also authorized the Social Security Administration and the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors, to release to Key Risk information concerning his or her workers compensation injury, entitlement dates and benefit amounts.

The undersigned further authorizes Key Risk to release any such information to its reinsurers, attorneys, second injury fund consultants, or to medical laboratories, medical peer review panels, CMS, state insurance or fraud agencies, managed care vendors, industry anti-fraud or law enforcement organizations, research and statistical reporting organizations, or the undersigned's employer and its excess insurer, to the extent that Key Risk considers doing so to be reasonably appropriate or necessary for the purposes of its administration of the Claim or the insurance program under which the Claim has been made.

Information disclosed to Key Risk is from records whose confidentiality is protected by various state or federal laws. Any further disclosure of this information may no longer be subject to certain protections provided under federal privacy regulations. Unless revoked earlier by the undersigned, in writing, this authorization shall be valid for three years after Key Risk has closed the Claim. A copy of this authorization is to be considered as valid as the original.

Employee Signature ______________________ **Date** ______________________

Employee Name ______________________ **Employer** ______________________
(Please Print) **(Please Print)**

Claim Number ______________________ **Date of Birth** ______________________

Letter of Introduction to the Physician

Date: ______________________

Name of Provider: _____________________________________

Street Address or P.O. Box: _____________________________________

City, State Zip: _____________________________________

Dear Provider:

___________________________, an employee of, __________________________, has reported a possible work related injury or illness. We have filed a workers compensation claim with our carrier, Key Risk. Any authorization for treatment or referrals for additional treatment must be directed to Key Risk's claim call center at **866.847.8872**.

Key Risk will be responsible for making all compensability decisions regarding this workers compensation claim. If the claim is compensable, all medical bills will be paid directly by Key Risk under our workers compensation policy. Therefore, please forward all medical bills and medical reports **(note: bills cannot be processed without the appropriate supporting medical reports)** directly to:

Key Risk
P.O. Box 8000
Daphne, AL 36526-8000

The injured employee understands that if the claim is found not to be a compensable claim, he or she will be responsible for all bills related to your treatment.

We appreciate your cooperation and assistance. If you have any questions, please contact Key Risk's client service call center at **866.847.8872.**

____
(Employer)

____
(Date)

Physician's Report / Pharmacy Guide

MAILING ADDRESS: P.O. Box 49129, Greensboro, NC 27419
866.847.8872 www.keyrisk.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)**

______________________ **Facility Name**

______________________ **Facility Phone Number**

Contact Key Risk's Claim Department at 866.847.8872 for authorization for the referral.

PHARMACIST: Process all prescriptions through ***Optum*** for this patient. Contact ***Optum*** at (866) 599-5426 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 866.599.5426 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:

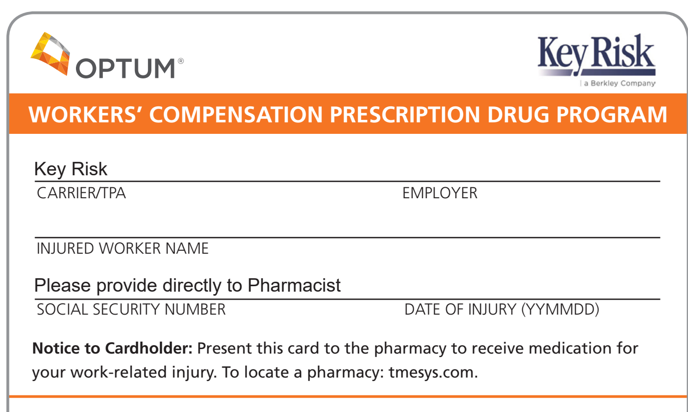
If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

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 and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit www.tmesys.com.

Questions? Need Help?

1-866-599-5426


OPTUM
KeyRisk
a Berkley Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Key Risk
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.

Tmesys Pharmacy Help Desk
1-800-964-2531

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

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.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."

IMP14-1614-109-KRSKFF

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 su empleador o su asegurador. 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 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 www.tmesys.com.

¿Tiene alguna pregunta? ¿Necesita ayuda?

1-866-599-5426

OPTUM® | Key Risk | a Berkley Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Key Risk
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.

Tmesys Pharmacy Help Desk
1-800-964-2531

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

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.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."

IMP14-1614-109-KRSKFF