OFFICE OF HUMAN CAPITAL MANAGEMENT
Benefits & Risk Management

Midland Independent School District
615 W. Missouri Ave., Midland, TX 79701
432-240-1000 • midlandisd.net

Workers' Compensation Packet

Please see the steps below to follow in the event an employee is injured on your campus and is planning to seek medical treatment. **All steps must be followed prior to the employee seeking medical treatment** unless the injury is a medical emergency and the employee is unable to complete the forms before treatment.

☐ Step 1: First Report of Injury (FROI)

Have the injured employee complete the paper FROI and give it to their campus secretary. The campus secretary must enter the information on the TASB website no later than 24 hours from the injury. **The original FROI must be sent to The Benefits Department as soon as possible. Click here for secretary instructions on how to file the FROI online.**

☐ Step 2: Employee Acknowledgement of the Alliance Program

Please have the injured employee sign and date this form. Make a copy for the employee and send the original signed form to The Benefits Department.

☐ Step 3: Advise Employee of Treating Physician for Workers' Compensation

Nova Medical Center
2501 W. Illinois Ave
Midland, TX 79703
(432) 203-0200

****If the employee does not go to our designated Workers' Compensation physician they run the risk of their medical and/or income benefits being disputed.**

☐ Step 4: Provide Employee with Temporary Rx Prescription Card

The employee will use this prescription card if any medication is prescribed to them due to their workers' compensation injury. **Please advise the employee not to use their Blue Cross Blue Shield Rx Card for their workers' compensation injury.**

☐ Step 5: Have the Employee Complete the Leave Election Form

The employee must sign the leave election form to advise if they are wanting to use their available leave when out of work due to a work-related injury. This is required in order to determine how to code their absences in Frontline. **If the employee is losing time please notify the Benefits Department as soon as possible (432) 240-1824.**

Texas Association of School Boards Risk Management Fund (TASBRMF) administers MISD Workers' Compensation Claims. The injured employee should expect a call from a TASBRMF Workers' Compensation Adjuster once their claim has been set up. 1-800-580-8272.

Worker's Compensation Injury Information

Injured Employee: Please complete the following information & return it to the campus secretary.

Secretaries: The FROI must be completed online by clicking here.

Send the original documents to the Benefits Department within 1 business day.

GENERAL INFORMATION

Campus Location where injury occurred:			
Employee Last Name:		First Name:	
Mailing Address:	City:	State:	Zip:
Best Contact number:		Date of Birth:	
Social Security:		Date Hired:	
Sex: ☐ Male ☐ Female		Number of dependents:	
Marital Status: ☐ Married ☐ Unmarried ☐ Seperated ☐ Unknown			
Occupation/ Job Title:		Employee ID #:	

WAGE INFORMATION

Rate: $ ☐ Per Week ☐ Bi-Weekly ☐ Monthly ☐ Hourly ☐ Daily	
Days Worked Per Week:	Full Pay for Day of Injury? ☐ Yes ☐ No
Do You Elect to Use Paid Leave instead of Temporary Income Benefits ☐ Yes ☐ No ☐ Unknown	
If so, how many leave hours/ days do you elect to use? ☐ Hours ☐ Days	

INJURY INFORMATION

Type of Claim: ☐ **Record Only** (No treatment/No Lost time) ☐ **Medical Only** (Treatment Sought) ☐ **Lost Time**	
Date of Injury:	Time of Injury: AM or PM
Date Employer Notified:	Date Lost Time Began:
Supervisor's Name:	Supervisor's Phone:
Type of Injury: ☐ Bite ☐ Burn ☐ Contusion ☐ Fracture ☐ Sprain/Strain ☐ Unknown	
Witness Information:	Dept. Location where injury occurred:
Cause of Injury: ☐ Fall/Slip ☐ Trip ☐ Lifting ☐ Pushing ☐ Cut ☐ Other_____	
Did injury occur on MISD Property? Yes or No	Date returned to work:
Explain how you were injured:	
What body part(s) was injured? Right or Left?	

MEDICAL TREATMENT INFORMATION

Name of Doctor or Facility:	Address
Initial Treatment: ☐ No Medical Treatment ☐ ER ☐ Minor by employer ☐ Minor ☐ Future Medical/ Lost Time	

_____ _____

Employee Signature **Date**

Employee Acknowledgement 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: Midland ISD

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 **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.

TASB™ RISK FUND

TASB Risk Management Fund

OPTUM®
PO Box 152539
Tampa, FL 33684-2539

TASB RISK FUND

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 tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

TASB Risk Mgmt. Fund — CARRIER/TPA
Midland ISD — 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	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®

IMP14-1813-37

FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION (NO OFFSET—ENGLISH VERSION)

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 the extent that paid leave does not equal my pre-illness or -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 Midland ISD 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 receive only workers' compensation wage benefits for any absences resulting from my work-related illness or 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 employees only:* Hourly rate: $____.___ Number of hours paid: _____

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

Please take this form to the doctor for your first medical examination.

Employee Name_____ Date of Injury _____

Date of Birth_____ Social Security _____

Reported Work Related Injury or Illness:

_____

_____

Midland ISD _____(member organization) 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 pswca.org.

Please submit all claim and medical billing information to:

TASB
P.O. Box 2983
Clinton, IA 52733-2983
Phone: 800.732.0153
Fax: 732.212.7009

eBill Information
Clearinghouse: WorkComp EDI
Clearinghouse website: www.workcompedi.com
TASB's Payer ID: WR902

Pre-Authorization
Phone: 800.482.7276, x9907
Fax: 888.777.8272

Issuing Signature_____ Title _____

Phone Number_____ Date _____

Providers please submit Work Status Reports and all Job Description inquiries to:

Contact Name, Title Benefits Department

Phone 432.240.1950

Fax 432.689.5869

Email benefits@midlandisd.net

For a full list of Alliance Providers please visit pswca.org.