WORKERS COMPENSATION

RISK MANAGEMENT FACT SHEET

WHAT YOU SHOULD KNOW AND WHAT YOU SHOULD DO IF INJURED ON THE JOB

Incase of a **LIFE THREATENING** or **MAJOR EMERGENCY**, **call 911 or go to the nearest hospital! Contact Risk Management and your supervisor as soon as possible.** For a NON-LIFE-THREATENING EMERGENCY, report your injury to your supervisor/department head and the Risk Management Department PRIOR TO SEEKING MEDICAL TREATMENT. If medical treatment is necessary, immediately go to the medical walk-in clinic listed below.

JET MEDICAL CENTER
1838 JACLIF COURT
TALLAHASSEE, FL 32308
850-889-1234

For injuries that occur Monday through Friday between the hours of 8am and 5pm, follow the non-emergency steps listed above. You will be instructed where to go for medical attention by the Risk Management Department.

For NON-LIFE THREATENING injuries that occur after hours, weekends, and holidays, call 855-223-3755 or 850-274-3450. If your call is not answered, obtain treatment at the hospital or walk-in facility below.

Tallahassee Memorial Emergency
1260 Metropolitan Blvd.
Tallahassee, FL 32312
THIS IS NOT A HOSPITAL

In either instance, you are required to complete the Worker's Comp Paperwork within 24 hours following the injury or as soon as possible thereafter.
EMAIL ALL WORKER'S COMP DOCUMENTS TO KEATONC@LEONSCHOOLS.NET OR FROI.RISKMANAGEMENT@LEONSCHOOLS.NET

For assistance, please call:

Tod Stupski
Director
(850) 561-8359 office
(850) 274-3450
Tod.Stupski@leonschools.net

Cheryl K Griffin
Project Manager
(850) 561-8357 office

Cheryl.Keaton@leonschools.net

LEON COUNTY SCHOOLS

Davies

Davies Group
P.O. Box 16688
Tampa. Florida 33887

813-288-3551 phone
866-434-2475 fax

Medical Release: You are hereby authorized and requested to discuss and furnish any and all information, including reports, records, memorandum notes, X-rays, insurance claims, and bills in your possession, custody, or control to CorVel Corporation and The Leon County School Board, or any of their authorized agents regarding any injury, disease or medical condition pertaining to your physical, mental, or psychiatric condition past, present, and future. A photo copy or facsimile of this authorization should likewise be honored.

Co-Pay Notification: Medical bills are paid per the Worker's Compensation Fee Schedule. For injuries that occur after 01/01/1994, the injured person is responsible for the $10.00 co-pay after reaching the maximum medical improvement.

Please list the name(s), address(es), and phone number(s) of physicians you have seen in the past 10 years:

_____

_____

_____

_____

_____

_____

Your Name: _____

Social Security Number: _____

Date of Birth: _____

Month **Day** **Year**

FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

For assistance call 1-800-342-1741
or contact your local EAO Office

RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last)

Social Security Number

Date of Accident (Month-Day-Year)

Time of Accident ☐ AM ☐ PM

HOME ADDRESS

Street/Apt #: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)

OCCUPATION

INJURY/ILLNESS THAT OCCURRED

PART OF BODY AFFECTED

DATE OF BIRTH _____ / _____ / _____

SEX ☐ M ☐ F

EMPLOYER INFORMATION

COMPANY NAME: Leon County School Board

D. B. A.: Leon County Schools

Street: 2757 W. Pensacola Street

City: Tallahassee State: Florida Zip: 32304

TELEPHONE Area Code Number

(850) 487-7100

FEDERAL I.D. NUMBER (FEIN)

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

POLICY/MEMBER NUMBER

DATE EMPLOYED _____ / _____ / _____

PAID FOR DATE OF INJURY ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)

Street: _____

City: _____ State: _____ Zip: _____

LOCATION # (If applicable) _____

LAST DATE EMPLOYEE WORKED _____ / _____ / _____

RETURNED TO WORK ☐ YES ☐ NO
IF YES, GIVE DATE _____ / _____ / _____

WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? ☐ YES

LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP _____ / _____ / _____

PLACE OF ACCIDENT (Street, City, State, Zip)

Street: _____

City: _____ State: _____ Zip: _____

COUNTY OF ACCIDENT _____

DATE OF DEATH (If applicable) _____ / _____ / _____

AGREE WITH DESCRIPTION OF ACCIDENT? ☐ YES ☐ NO

RATE OF PAY ☐ HR ☐ WK

$ _____ PER ☐ DAY ☐ MO

Number of hours per day _____

Number of hours per week _____

Number of days per week _____

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234. Section 440.105(7), F.S.

I have reviewed, understand and acknowledge the above statement.

_____ EMPLOYEE SIGNATURE (If available to sign) _____ DATE

_____ EMPLOYER SIGNATURE _____ DATE

NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL

Where did the IW seek medical treatment?

AUTHORIZED BY EMPLOYER ☐ YES ☐ NO

CLAIMS-HANDLING ENTITY INFORMATION

☐ 1(a) Denied Case - DWC-12, Notice of Denial Attached

☐ 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached

☐ 2. Medical Only which became Lost Time Case (Complete all required information in #3)

Employee's 8TH Day of Disability _____ / _____ / _____

Entity's Knowledge of 8TH Day of Disability _____ / _____ / _____

☐ 3. Lost Time Case - 1st day of disability _____ / _____ / _____ Full Salary in lieu of comp? ☐ YES Full Salary End Date _____ / _____ / _____

Date First Payment Mailed _____ / _____ / _____ AWW _____ Comp Rate _____

☐ T.T. ☐ T.T. - 80% ☐ T.P. ☐ I.B. ☐ P.T. ☐ DEATH ☐ SETTLEMENT ONLY

Penalty Amount Paid in 1st Payment $_____ Interest Amount Paid in 1st Payment $_____

REMARKS:

INSURER NAME

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

Davies North America
PO Box 110259
Lakewood Ranch, FL 34211-0004
(800) 749-3044

INSURER CODE #

EMPLOYEE'S CLASS CODE

EMPLOYER'S NAICS CODE

SERVICE CO/TPA CODE #

CLAIMS-HANDLING ENTITY FILE #

DWC-1 Purpose and Use Statement

The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.

Mitchell ScriptAdvisor

Davies

FAST & SIMPLE: GETTING YOUR FIRST PRESCRIPTION FILLED

Mitchell ScriptAdvisor has been selected by **Davies** to assist in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply present it at the pharmacy at the time your prescription is filled. This form should ensure that you will have NO out-of-pocket expenses.

Please Note: This is a temporary prescription card; you may receive a permanent drug card in the future.

For your convenience, **Mitchell** ScriptAdvisor has an extensive network of retail pharmacies including major chain drug stores. For pharmacy locations, you may call our toll-free number at 866.846.9279 or visit our website at https://portal.mitchellscriptadvisor.com/main/pharmacylocator.aspx to access the pharmacy locator.

Employee

- You may contact Mitchell Customer Service at 866.846.9279 or you may present this sheet to the pharmacist along with your prescription.
- We ask that your doctor not dispense medications from the office, but instead provide you with a prescription for the requested medications, including over-the-counter medications. You can fill your prescription at any participating local pharmacy.

Pharmacy

- This sheet is a Temporary Prescription ID Card for up to a 10 Days' Supply Fill until this individual's permanent card can be provided.
- **Create the ID number** based off the criteria provided and write it, along with individual's name, on the ID card below.
- All data needed to process this script through the Script Care Adjudication System is included in the drug card represented below.

Mitchell ScriptAdvisor

Temporary Prescription Benefit Card

SCRIPT CARE, LTD.

Attention Pharmacists: Process through Script Care and Enter RxBIN, RxPCN and GROUP.

Member Name:

Member ID #:

Date of Injury + Date of Birth (Example: MMDDYYMMDDYY)

Rx BIN:	023377
PCN:	MPS
Group:	001790TC

Questions? Need Help?

Call (866) 846-9279

Our representatives are available 24/7 to answer any questions you may have regarding your pharmacy benefits.

This card is to be used for prescriptions related to your workers' compensation injury covered under the workers' compensation insurance policy. Use of this card does not waive any limitations or exclusions for the policy. This card does not confirm coverage. To confirm eligibility or obtain specific information, please contact the Help Desk with the information from the front of this card.

mitchell

Mitchell International
866.846.9279

Pay Period on Worker's Compensation Benefits

Injured workers are entitled to payments under worker's compensation statute if they cannot return to work as a result of severe injuries. If you are severely injured and are paid pursuant to state law, you are eligible to receive bi-weekly worker's compensation payments. By signing this agreement, you agree to be paid at your normal pay period as if you were able to work.

Name: _____

Please Print

Signature: _____