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 FROI.RISKMANAGEMENT@LEONSCHOOLS.NET OR KEATONC@LEONSCHOOLS.NET.**

For assistance, please call:

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

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

keatonc@leonschools.net

LEON COUNTY SCHOOLS

CORVEL

CorVel Enterprise Corp.
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**

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 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.

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

LEON COUNTY SCHOOLS

2757 West Pensacola St.
Tallahassee, FL 32304

FEDERAL I.D. NUMBER (FEIN)

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

POLICY/MEMBER NUMBER

TELEPHONE Area Code 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

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

CORVEL

855-223-3755

INSURER CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE
SERVICE CO/TPA CODE #	**CLAIMS-HANDLING ENTITY** FILE #	

Injured Worker's First Fill Prescription Form

Employee Name:_____

Date of Injury:_____ **SSN:**_____

Injured Worker Instructions:
On your first pharmacy visit, please give this notice to any pharmacy listed on this insert. This will expedite the processing of your approved worker's compensation prescriptions based on the parameters established by **Leon County Schools.** With the CorVel Pharmacy Program, you do not need to complete any paperwork or claim forms. Simply present this CorVel First Fill Prescription Form to the pharmacy. You should not incur any costs or co-pays at the pharmacy. You will be allowed up to a 14-day supply of most medications.

Notice to Injured Worker and Pharmacy:
This temporary First Fill Card is only valid if used within 30 days of the reported injury date. Temporary eligibility through this program allows for a one-time fill of prescription medications.

Pharmacy Instructions:
For assistance processing claims, please contact the CorVel Pharmacy Department at (800) 583-8438. Please use Bin, PCN, and RxGroup number below to process an online/electronic claim to Corvel:

Bin:	**004336**
PCN:	**ADV**
RxGroup:	**RXFFWC9125227**
Member ID:	**See below to generate ID**

To generate member ID: The injured Worker's 9-digit social security number and 8-digit date of injury will be used as their 17-digit member identification number when processing their First Fill Prescription.

Below is a sample listing of some of the over 62,000 participating pharmacies in the CorVel Network. Please call (800) 563-8438 for a participating pharmacy near you.

Costco Pharmacy	H.E.B. Pharmacies	Meijer Pharmacy	Smith's Food and Drug Centers
CVS	Hy-Vee Pharmacy	Publix Pharmacy	Target Pharmacy
Duane Reade	Ingles Pharmacy	Raley's Drug Center	Von's Pharmacy
Drug Mart	Kroger Pharmacy	Rite Aid Pharmacy	Wal-Mart Pharmacy
Fred's Pharmacy	Longs Drug Store	Safeway Pharmacy	Walgreens Pharmacy
Giant Eagle Pharmacy	Marc's Pharmacy	Sav-On Drug Store	Wegman Pharmacy

Opioid Safety:
What you need to know

Opioid misuse and abuse is a growing concern in our country. You may be taking (or have taken) a prescribed opioid such as oxycodone to help relieve pain. Drugs like these are generally safe when taken exactly as directed for a limited period, but can become harmful – even fatal – if misused. It's important to be informed about the risks and benefits of opioid medication use should your doctor prescribe them to manage your pain.

Prescription opioids can help to manage short-term pain that may occur after a surgery or recent injury. But they may not work as well to manage chronic pain long-term. In addition, you're more likely to overdose or become addicted when using opioids for extended periods of time. An overdose can cause serious health problems or even death. There may be other treatments available with less serious risks. Work with your doctor to find the safest, most appropriate ways to manage your condition.

As many as

1 in 4

taking prescription opioids struggle with addition when opioids **are used long term.** [1]

Safety tips to consider when you are prescibed opioid medication:

- Always take your medication exactly as instructed by your doctor.
- Never share your opioids with others.
- Avoid alcohol and certain medications that may interact with your opioids.
- Review your medication list with your doctor.
- Follow up regularly with your doctor.
- Store opioids in a secure place, ideally a locked location.
- Dispose of unused opioids properly. Check with your pharmacy regarding disposal methods.

Please note: Some insurance plans may allow opioid fills with a limited day supply. Please call CorVel Pharmacy Solutions at (800) 563-8438 with any questions regarding your plan.

1. Prescription opioid overdose data. U.S. Centers for Disease Control and Prevention. Last updated August 1, 2017. https://www.cdc.gov/drugoverdose/data/overdose.html. Accessed January 10, 2018.

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: _____