



New Injury Packet

Workers' Compensation Guide for Injured Employees

TPA Information:

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Employer's Checklist

When a new injury occurs, it is important for all employers to have clear instructions on how to fill out forms, file paperwork, and what to give the injured employees. Use this guide to complete tasks regarding the injured employee. Check off each task when it is completed and sign the bottom of this form. Keep this information for your records.

Have Injured Employee Fill Out:

- Employee's Injury Report
- HIPAA Authorization Form

To help expedite the claims process, these forms can be sent to:

ClaimsMail@cas-services.com

Give Injured Employee:

- Injured Employee Checklist
- Workers' Compensation Prescription Information
- MyMatrixx Prescription First Fill Card Form
- MyMatrixx Participating Pharmacies List
- Notice of Injured Worker's Rights & Responsibilities

New Injury Packet Completed By:	
Employer Representative Name	
Employer Representative Signature	
Date	

Employee Injury Report

This form must be completed in detail and signed by the injured employee.

Employee Information			
Your Full Name			
Employer		Location of Accident	
Social Security Number (Last 4 Digits) XXXX-XX-	Date of Birth	Department You Work For	
Your Address (Street, City, State, County, Zip)		Supervisor's Name	
Phone Number Where You Can Be Reached		Job Title at Time of Injury	
Date of Hire		How Long in Current Position? _____Yrs. _____ Months	

Details of the Injury		
Date of Injury	Time of Injury AM / PM	Date You First Lost Time
Where in the workplace did your injury occur?		
Describe in detail how your injury occurred.		
What safety equipment were you using at the time of the accident?		
What can be done to prevent this type of injury in the future?		
When were you first aware of this injury?		
When did you first notify your supervisor of your injury?		

Employee Injury Report

What part of your body is injured?	Describe the injury.
On the diagram below, please circle the part(s) of your body where you are experiencing pain due to this injury.	
Did anyone witness your accident? List the names of any witnesses.	
Was anyone else injured in this accident? List the names of any other injured people.	
In the incident that caused your injury, was there damage to any property or equipment? Describe any damage.	

- ✓ I certify that the information contained in this report is true and correct.
- ✓ I understand that any falsification of information regarding an on-the-job injury may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes.
- ✓ I hereby authorize the release of all medical records relating to the above-noted incident to my employer, their agent, or insurance company.

Employee's Printed Name	Employee's Signature	Date
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- ✓ I certify that the above employee has acknowledged to me that he/she understood all questions and signed and dated this form in my presence on this date.

Witness Printed Name	Witness Signature	Date
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Supervisor's Printed Name	Supervisor's Signature	Date
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HIPPA Authorization Form

Disclosure of Protected Health Information

I, (Name) _____, (Date of Birth) _____, (SSN) _____, authorize the disclosure of my protected health information* as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws**, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below):
 - + All healthcare providers who have provided healthcare to me.
2. I authorize the following person(s) and/or organizations to receive my protected health information as disclosed by the person(s) and/or organization(s) above.
 - + Claims Administrative Services, Inc.
P.O. Box 7500, Tyler, Texas 75711
 - + Texas Department of Insurance – Division of Workers’ Compensation
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1609
 - + Others: _____
3. Specific description of the protected health information that I authorize for disclosure:
 - + Any and all records regarding my health, including medical histories, consultations, examinations, prescriptions, diagnoses, tests, reports, or treatments.
 - + I further specifically authorize the disclosure of psychotherapy notes, if any.
4. The purpose of requesting this information is for use by the carrier to evaluate, adjust, describe, or report matters about my health to persons entitled to receive this information.
5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.
6. I understand that treatment and payment for my treatment are not conditioned on my agreement to this authorization.
7. I understand that the release of protected health information to a non-covered entity may invalidate its protection.
8. I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all healthcare information related to such diagnosis, testing, or treatment.
9. This authorization expires one year from the date of authorization or the date that my workers’ compensation claim is finally closed, whichever occurs first.

I have had the opportunity to read and consider the contents of this authorization. I confirm that this authorization is a true and correct statement of my intention to permit the disclosure of my PHI as described in this authorization.

Signature		Date	
Name			
Address			
Phone Number	SSN (Last 4 Digits Only) XXX-XX-	Date of Birth	

*Protected health information (“PHI”) is health information that is created or received by a health care provider, health plan, or health care clearinghouse that relates to 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508 **These laws apply to health plans, health care providers, and health care clearinghouses.

Injured Employee Checklist

The following information will help you recover from your injury, resume your normal work activities, and return to work as soon as possible.

Give Your Doctor:

- Workers' Compensation Claim Number
- Division of Workers' Compensation Claim Number
- Employer's Name & Phone Number
- Information Regarding Your Job or Other Work Opportunities
- Claim Adjuster's Name & Phone Number

General Reminders:

- ✓ Go to all your medical appointments.
- ✓ Follow your doctor's directions carefully.
- ✓ Talk to your doctor to see if you can continue to work, even if you have some restrictions.
- ✓ Share a copy of your job description to help your doctor understand your specific work demands.
- ✓ Talk to your doctor to make sure you completely understand what you can and cannot do while you are recovering.
- ✓ Comply with the medical restrictions set by your doctor at home and at work.

You & Your Employer:

- ✓ Make sure you have received and reviewed your 'Injured Worker Rights and Responsibilities.'
- ✓ Follow all employer policies and requirements associated with your workers' compensation injury.
- ✓ Be sure to keep your employer and claims adjuster informed and up-to-date on your recovery and current abilities.
- ✓ Talk to your employer about work that you could continue to do during your recovery.
- ✓ Notify your employer and claims adjuster immediately if your work status changes.

Getting Back to Work:

- ✓ Communicate with your employer so that you can return to productive work as soon as medically possible.
- ✓ Contact your adjuster when your work status changes to ensure that appropriate benefit payments are made.
- ✓ Help your employer determine what additional work you could take on as your condition improves.
- ✓ If work within your restrictions is not immediately available, keep checking back with your employer. As you continue to recover, the situation may change.
- ✓ Be sure to let your employer know about any concerns or problems you might have related to your health and job assignments.

By continuing to work during your recovery, healing will likely progress more quickly and effectively than if you perform no work at all for an extended period of time. You will also have a much more productive mindset that can in fact help speed your recovery.

Prescription Card Information

If prescriptions are issued during the course of treatment for your work-related injury, the following information will help guide you through the process of accessing necessary medications. Your prescription program is processed by MyMatrixx and this packet contains your “Temporary Prescription Card” as well as a list of “Participating Pharmacies.” Below are some common questions about how the card works, its benefits, and how to use it effectively.

What is this card?

This card is for your workers’ compensation prescription needs. Please take this card to the pharmacy when you are filling prescriptions for your work-related injury.

Why did I receive this card?

You received this card due to an injury that occurred on the job.

What if I am not currently taking any medications due to the injury?

Please keep the card in a safe place in case you start taking medications for your current injury.

When should I use this card?

Any time you need to fill a prescription for your work-related injury.

Are all medications pre-approved?

Your insurance company may have pre-selected medications that will go through without authorization. If you drop off a prescription at the pharmacy and it is rejected for any reason, the pharmacy should call us and we will call your insurance company for approval. If you would like to know the types of medications that are pre-approved before going to the pharmacy, please call 877-804-4900, and a customer service representative will be happy to assist you.

Can my family members use this card?

No, this is only for your work-related injury.

What should I do if there is a problem with the card when I take it to the pharmacy?

Your pharmacy should call us with any problems they are having with the card. If for ANY reason they do not call us, or if you have any questions regarding your work-related medications, please call our customer service team at 877-804-4900.

Are you my workers’ compensation insurance company?

No, we are contracted by your workers’ compensation insurance company to handle all of your work-related prescription needs.

What happens if my medication doesn’t provide relief from my symptoms or pain?

You should contact your doctor or pharmacist to verify that the medication prescribed for your pain is the most appropriate for your condition.

Should I tell my doctor about other medications I am taking not related to my work injury?

Yes. It is very important that your physician and pharmacist know ALL the medications you are currently taking. Some medications may counter the effect of other medications you are taking and some may even be harmful or life-threatening when taken together.

Can I talk to one of your pharmacists if I have a question?

Yes, our pharmacists are available to answer all of your medication-related questions.

MyMatrixx

By ~~EVERNORTH~~

To the Injured Worker:

On your first visit, please give this form to any pharmacy listed on the back side to speed processing of your approved work-related injury prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the MyMatrixx Patient Care Contact Center at 800.945.5951.

Atencion Trabajador Lesionado:

En su primera visita, entregue este formulario a cualquier farmacia que se encuentre en el reverso del boleto para acelerar el procesamiento de sus recetas aprobadas para lesiones relacionadas con el trabajo (según las reglas establecidas por su empleador).

¿Tiene preguntas o necesita ayuda para localizar una farmacia participante? Llame al centro de contacto para pacientes de MyMatrixx al 800.945.5951.

Temporary Prescription Card

ID#: _____

Your SSN is your temporary ID.

RxBIN#: 003858

PCN: WC

RxGroup #: PAWA

Date of Injury: _____
MM/DD/YYYY

For Workers' Compensation Only

Employee Information

Full Name _____

Street Address or PO Box _____

City _____

State _____

ZIP _____

Date of Birth _____

Employer Name _____



To the Pharmacist:

MyMatrixx administers this Workers' Compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 30-day supply or a cost of \$500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary.

For assistance, please call MyMatrixx at 888.786.9640.

Processing Steps:

1. Enter RxBin 003858
2. Enter PCN WC
3. Enter Rx Group Number PAWA
4. Enter 9-digit member ID (Patient SSN)
5. Enter Date of Injury

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

AHF PHARMACY
AHOLD CORPORATION
ALBERTSONS
ALIGNRX LLC
AMERITA INC
AURORA PHARMACY INC
BIG Y FOODS INC
BI-LO HOLDINGS LLC
BROOKS/MAXI DRUG
BROOKSHIRE BROTHERS LTD
CARDINAL HEALTH
CHEN NEIGHBORHOOD MEDICAL CENT
COBORN'S INC.
COSTCO WHOLESALE, INC
CVS CORP
DEDICATED US HOLDINGS LLC
DISCOUNT DRUG MART
ECKERD
EPIC PHARMACY NETWORK
ESSENTIA HEALTH
EXPRESS RX
FAIRVIEW PHARMACY SVCS
FAMILY FARE, LLC
FOOD LION PHARMACY

FRUTH PHARMACY
GENOA HEALTHCARE LLC
GIANT EAGLE PHARMACY
GUARDIAN PHARMACY LLC
HAC INC
HANNAFORD BROS. CO.
HARPS FOOD STORES INC
HARTIG DRUG
HEALTH MART ATLAS LLC
H-E-B LP
HENRY FORD HEALTH SYSTEM
HOMETOWN PHARMACY INC
HY-VEE FOOD STORES INC
INGLES MARKETS
INSTYMEDS CORP
KPH HEALTHCARE SERVICES
KS PHARM LLC
K-VA-T FOOD STORES INC
LEWIS DRUGS INC
LONGS DRUG STORE
MARC GLASSMAN INC
MEDICAP PHARMACY, INC.
MEDICINE SHOPPE
MEIJER PHARMACY
MERCY PHARMACY SERVICES

NCS HEALTHCARE
NEIGHBORCARE PHARMACY
OSBORN DRUGS INC
PATIENT FIRST
PHARMEDQUEST PHARMACY
PHARMERICA, INC
PMR US HOLDINGS
PRESBYTERIAN MEDICAL
PRESCRIBEIT RX
PRICE CHOPPER PHARMACY
PUBLIX SUPER MARKETS, INC
RALEY'S
RECEPT PHARMACY LP
RITE AID CORPORATION
SAFEWAY, INC.
SAM'S CLUB
SUPERVALU PHARMACIES, INC.
TARGET
THRIFTY WHITE STORES
TOPS MARKETS LLC
UNITED SUPERMARKETS INC
WALGREENS
WAL-MART
WEGMANS FOOD MARKETS,
WEIS MARKETS INC

Visit www.MyMatrixx.com to locate a participating pharmacy near you!



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 (OIEC). 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 (TDI). TDI is the State agency that administers and regulates the workers' compensation system through the Division of Workers' Compensation (DWC).

Many services provided by OIEC and DWC can be completed over the telephone. You can contact OIEC by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). Additional information, including office locations, is available on the Internet at: www.oiec.texas.gov. You can contact DWC by calling the toll-free telephone number 1-800-252-7031. Information about DWC is available on the Internet at: www.tdi.texas.gov.

Your Rights in the Texas Workers' Compensation System:

1. You have the right to hire an attorney to help you with your workers' compensation claim.

For assistance locating an attorney, contact the State Bar of Texas' lawyer referral service at 1-877-983-9227 or <http://www.texasbar.com/>. Attorney referral information can also be found on OIEC's website at www.oiec.texas.gov.

2. You have the right to receive assistance from OIEC if you do not have an attorney.

OIEC Customer Service Representatives and Ombudsmen are available to answer your questions and provide assistance with your workers' compensation claim by calling OIEC or visiting an OIEC office. **You must sign a written authorization before an OIEC employee can access information on your claim.** Call or visit an OIEC office to fill out the written authorization. Customer Service Representatives and Ombudsmen are trained in the field of workers' compensation and can help you with scheduling a dispute resolution proceeding about your workers' compensation claim. An Ombudsman can also assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot make decisions for you or give legal advice.

3. You may have the right to receive medical and income benefits regardless of who was at fault for your injury, with certain exceptions. Your beneficiaries may be entitled to death and burial benefits.

Information about the exceptions can be found at www.tdi.texas.gov or by visiting with OIEC staff.

4. You may have the right to receive medical care to treat your workplace injury or illness for as long as it is medically necessary and related to the workplace injury.

You may have the right to reimbursement of your incurred expenses after traveling to attend a medical appointment or required medical examination if the trip meets qualifying conditions.

5. You may have the right to receive income benefits for your work-related injury.

There are several types of income benefits and eligibility requirements. Information on the types of income benefits that may be available and the eligibility requirements can be found at www.tdi.texas.gov or by visiting with OIEC staff.

6. You may have the right to dispute resolution regarding income and medical benefits.

You may request Medical Dispute Resolution if you disagree with the insurance carrier regarding medical benefits. You may request Indemnity (Income) Dispute Resolution if you disagree with the insurance carrier regarding income benefits. The law provides that your dispute proceedings will be held within 75 miles from your residence.

7. You have the right to choose a treating doctor.

If you are in a Workers' Compensation Health Care Network (network), you must choose your doctor from the network's treating doctor list. You may change your treating doctor once without network approval. If you are not in a network, you may initially choose any doctor who is willing to treat your workers' compensation injury; however,

changing your treating doctor must be pre-approved by the DWC if you are not in a network. If you are employed by a political subdivision (e.g. city, county, school district,) you must follow its rules for choosing a treating doctor. It is important to follow all the rules in the workers' compensation system. **If you do not follow these rules, you may be held responsible for payment of medical bills.** OIEC staff can help you to understand these rules.

8. You have the right for your workers' compensation 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 DWC.

Your Responsibilities in the Texas Workers' Compensation System

1. You have the responsibility to tell your employer if you have been injured at work while performing the duties of your job. 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. If there is something you do not understand, ask your employer or call OIEC. If you would like to file a complaint about a network, call TDI's Customer Help Line at 1-800-252-3439 or file a complaint online at <http://www.tdi.texas.gov/consumer/complfrm.html#wc>.

3. If you worked for a political subdivision (e.g., city, county, school district) at the time of your injury, you have the responsibility to find out how to receive medical treatment. Your employer should be able to provide you with the information you will need in order to determine which health care providers can treat you for your workplace injury.

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

5. You have the responsibility to send a completed Employee's Claim for Compensation for a Work-Related Injury or Occupational Claim Form (DWC041) to DWC. 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 DWC041 form even if you already are receiving benefits. You may lose your right to benefits if you do not timely send the completed claim form to DWC. For a copy of the DWC041 form you may contact DWC or OIEC.

6. You have the responsibility to provide your current address, telephone number, and employer information to DWC and the insurance carrier. DWC can be contacted at 1-800-252-7031.

7. You have the responsibility to tell DWC and the insurance carrier anytime there is a change in your employment status or wages. (Examples of changes include: you stop working because of your injury; you start working; or you are offered a job).

8. Eligible beneficiaries or persons seeking death and burial benefits have the responsibility to send a completed Beneficiary Claim for Death Benefits (DWC-042) to DWC within one year following the employee's date of death.

9. You are prohibited from making frivolous or fraudulent claims or demands.