Injury Management Packet

Contents:

1) Injury Reporting Guide
2) Claim Reporting, Technology and Medical Bill Inquiries Contact Sheet
3) Employee Report of Injury (E)
4) Declination of Treatment (E)
5) Medical Provider Return to Work (RTW) Letter (E)
6) Work Status Report (E)
7) First Fill Form (E)
8) Medical Communication Authorization (S)
9) Supervisor Accident Investigation (S)
10) Witness Report (S)
11) Modified Duty Work Agreement (S)
12) Modified Duty Work Schedule (S)

Injury Reporting Guide

Reporting Process

All work-related accidents, injuries and near misses are to be reported immediately. Please follow the reporting guidelines below:

- Employee must report injury to supervisor immediately.
- Supervisor informs Human Resources & Safety immediately.
- Supervisor submits accident investigations to Human Resources by the end of the shift.
- All claims must be submitted to United Heartland within 1 business day.
- All workers have the right to report a work-related injury or illness, without being retaliated against.

In the case of a catastrophic or fatality claim, please contact United Heartland immediately at (800) 258-2667.

OSHA requires employers to report any worker fatality within 8 hours, and any amputation, loss of an eye or hospitalization of a worker within 24 hours at (800) 321-6742.

Resources and Responsibilities

Employee

The documents in this packet that are meant for employee use are labeled with a red box with an "E" in the upper right corner.

- Fill out Employee Report of Injury (p. 3)
- Sign the "Medical Communications Authorization" (p. 9) and give to supervisor.
- Take the following forms to medical provider:
  - Medical Provider Return To Work (RTW) Letter (p. 5)
  - Work Status Report/Medical Service Form (p. 6)
  - Prescription First Fill Form (p. 7 and 8)
  - Must provide completed Work Status Report/Medical Services Form to HR after every appointment, before you return to work.

Supervisor

The documents in this packet that are meant for supervisor use are labeled with a tan box with an "S" in the upper right corner.

- Ensure proper medical attention is sought. Refer to occupational health clinic unless it is an emergency.
- Have the employee sign the "Medical Communications Authorization" (p. 9).
- Send completed Employee Report of Injury to HR immediately.
- Complete Supervisor Accident Investigation (p. 10) within 24 hrs.
- Send completed Supervisor Investigation and Witness Statements (p. 10 and 11) to HR within 5 days.
- Review and accommodate modified duty instructions from Work Status Report. HR will assist with modified duty placement as needed.
- Once modified duty has been identified, fill out Modified Duty Work Agreement with the employee (p. 12)
- Each week fill out the Modified Duty Work Schedule with the employee (p. 13).
- Follow-up with employee until released to regular work.

Claim Reporting, Technology and Medical Bill Inquiries Contact Sheet

Catastrophic or Fatal Claim Reporting

Contact United Heartland immediately at (800) 258-2667.

Claim Reporting

1. **Online:** UnitedHeartland.com using your provided ID and password information
2. **Email:** ClaimsExpress@UnitedHeartland.com
3. **Fax:** (866) 814-5595
4. **Phone:** (888) 881-8242
5. **TeleCompCare®:** Upon contacting our telemedicine hotline, FNOL is auto-initiated

Report all claims, including incident-only claims, within one business day.

Medical Bill Inquiries

Mail to:
United Heartland
P.O. Box 40790
Lansing, MI 48901

Fax: (517) 316-2747

Call: (800) 258-2667

Information Technology Assistance

Please call **(800)258-2667** #6 for United Heartland and have your policy number or username available.

Employee Report of Injury

Name: _____ **Address:** _____
Phone #: _____ Birth Date: _____ Date of Hire: _____
Accident Occur on Premises: ☐ Yes ☐ No Detailed Location: _____
Date of Injury: _____ Time: _____ ☐ am ☐ pm Shift: _____
Date Reported: _____ **Witnesses:** _____

What were you doing just before incident occurred: _____

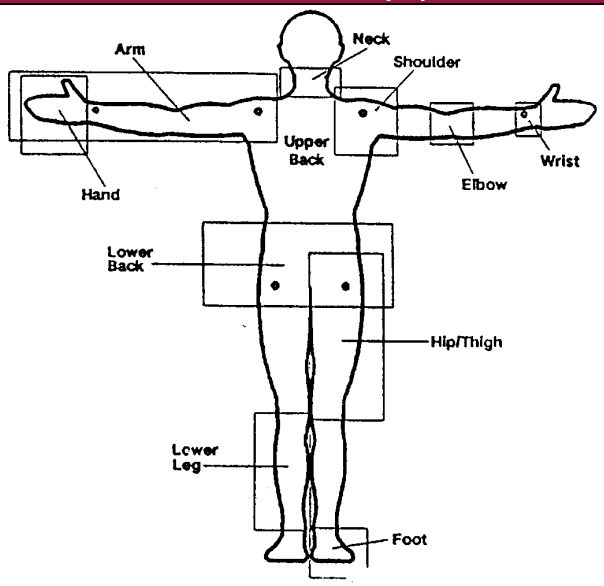
_____

Describe the accident in detail/what happened: _____

_____

What object or substance directly harmed the employee: _____

_____

Injured Area	Indicate Area of Injury	Type of Injury
1 ☐ Head 2 ☐ Eye: L/R 3 ☐ Shoulder L/R 4 ☐ Arm L/R 5 ☐ Elbow L/R 6 ☐ Wrist L/R 7 ☐ Hand L/R 8 ☐ Finger: Specify _____ 9 ☐ Back 10 ☐ Chest 11 ☐ Abdomen 12 ☐ Pelvis 13 ☐ Hip L/R 14 ☐ Leg L/R 15 ☐ Knee L/R 16 ☐ Ankle L/R 17 ☐ Foot L/R 18 ☐ Toe: Specify _____ 19 ☐ Other: _____	 **LEFT** **RIGHT**	1 ☐ Abrasion 2 ☐ Amputation 3 ☐ Bite: _____ 4 ☐ Bruise 5 ☐ Burn 6 ☐ Concussion 7 ☐ Cut/Laceration 8 ☐ Foreign Body 9 ☐ Fracture 10 ☐ Hearing Impaired 11 ☐ Infection 12 ☐ Pain: _____ _____ 13 ☐ Puncture 14 ☐ Rash/Dermatitis 15 ☐ Respiratory 16 ☐ Strain/Sprain 17 ☐ Other: _____ _____

Employee's suggested action to prevent recurrence: _____

_____

Employee Signature: _____ Date: _____

IMMEDIATE ACTIONS: Prior to resuming work following incident:

Any unsafe conditions with equipment or process that caused accident: ☐ Yes ☐ No Supervisor Signature _____
If yes, list condition and corrective actions to eliminate the conditions: _____

_____

THIS PAGE MUST BE COMPLETED AND SUBMITTED PRIOR TO LEAVING YOUR SHIFT

Declination of Treatment

It is our policy to provide prompt and appropriate medical treatment to employees for work-related injuries. There are situations that arise where notice of an injury may be made, and formal treatment is not necessary.

When an employee reports a work-related injury, the injury will be documented and treatment will be offered. An employee may indicate a preference not to have formal medical treatment. In the event that an employee declines medical treatment, we will have the employee sign this document indicating that they declined medical treatment. The company will continue to monitor the resolution of the complaints or injury until the time that the condition has been completely resolved. The employee will be asked to sign off that the condition has completely resolved.

In the event that a condition is not improving readily during the monitoring period, or should the condition worsen, the employee will be sent for an evaluation to make sure the condition is properly addressed. There may be situations where an employee is sent for a medical clearance examination following their report of injury, even though the injured employee has declined medical treatment.

Date of Injury: _____

Injured Employee's Name: _____

Supervisor's Name: _____

Body Part(s) Injured: _____

☐ **I am declining medical treatment at this time. Should my condition worsen, or should I change my mind regarding treatment, I know I must inform my supervisor immediately.** Date: _____

Injured Employee's Signature: _____

Supervisor's Signature: _____

☐ **My injury/injuries have completely resolved.** Date: _____

Injured Employee's Signature: _____

Supervisor's Signature: _____

Medical Provider Return to Work Letter

Subject: Modified Duty Program

Dear Health Care Provider:

Enter Company Name believes that the prevention of occupational injuries and illnesses cannot be overemphasized. The protection of our number one resource, our employees, is of paramount importance.

However, in the event of an occupational injury or illness, Enter Company Name believes that it is our responsibility to accommodate an employee by maintaining a Modified Duty Program. This program is designed to provide meaningful work activities for an employee during the time that they are rehabilitating, until they are able to return to their normal work assignment.

In order for this program to continue its success, a coordinated effort between the employee, their health care provider, Enter Company Name and our agents is imperative.

Please complete and return the attached Medical Representative's Return to Work Recommendations Form. Using your evaluation of the employee's ability to work, we are able to determine what modified duty work assignments are available.

Enter Company Name appreciates your cooperation. If you have any questions, please contact (designated person or department and phone).

_____
(Signed by Company Representative)

Name and Title of Company Representative

UnitedHeartland
Part of the AF Group

UnitedHeartland.com
1-800-258-2667

United Heartland
PO Box 40790; Lansing, MI 48901-7990
Fax: 866-814-5595

E

WORK STATUS REPORT/MEDICAL SERVICE FORM

EMPLOYEE INFORMATION:

Name: Date of Birth: / /

Social Security Number: / / Phone #: ( ) - ext.

Date of Injury: / / Time of Injury: ☐ a.m. ☐ p.m.

Job Description:

Employee to Receive Medical Attention at: ☐ Clinic ☐ Hospital ☐ Physician:

EMPLOYER INFORMATION:

Company:

Phone #: ( ) - ext. Date Notified: / /

Authorized Employer Signature: Date: / /

EMPLOYER HAS LIGHT DUTY WORK AVAILABLE

TO BE COMPLETED BY PROVIDER:

Diagnosis:

Date of Examination: / / Time: ☐ a.m. ☐ p.m.

Treatment Plan:
- ☐ Must return for re-evaluation on: / /
- ☐ To receive PT/OT services Duration: x week for weeks
- ☐ Surgery Scheduled: / /
  Time: ☐ a.m. ☐ p.m. ☐ Inpatient ☐ Outpatient
- ☐ No further care required. Discharge Date: / /

Expected Healing Time: Days Weeks Months

- ☐ Other:

Current Status:
- ☐ May work full duty now (no restrictions) / / (Date)
- ☐ May work light duty now with identified restrictions through / /
- ☐ Presently working as of: / /
- ☐ May not work until / / ☐ Full Duty ☐ Light Duty
- ☐ Lifting: Maximum weight in pounds
- ☐ Pushing: ☐ 0 ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50 ☐ 60
- ☐ Pulling:
- ☐ Bending: ☐ 0-2 ☐ 2-6 ☐ 6-10 ☐ 10-20 Maximum Times/Hour
  Degree of bend: ☐ 10-20 ☐ 20-45 ☐ Full
- ☐ No sitting ☐ No standing ☐ No walking
- ☐ Sitting job only ☐ No climbing or overhead work
- ☐ May not use: ☐ Right hand ☐ Left hand
- ☐ Keep dressing/wound clean and dry
- ☐ Medication may cause drowsiness. Use caution operating machinery or equipment.

Comments:

NOTE: If inpatient admission is scheduled, notify United Heartland immediately at: 1-800-258-2667

PROVIDER INFORMATION:

Physician Name: Phone #: ( ) - ext.

Physician Signature: Date: / /

Employee: To expedite prompt claim handling, this complete form is to be returned to your employer either on the same day of the appointment or, should lost time be incurred, it is to be forwarded to your employer the day following the appointment.

Workers' Compensation Temporary Prescription ID Card

myMatrixx by Evernorth

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

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

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame al Centro de Contacto para Atención a Clientes de Express Scripts, al 800.945.5951.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of $150. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call Express Scripts at 866.499.1903.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit SSN number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

myMatrixx, by Evernorth

SSN: _____

Do not use Claim Number. Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____ /_____ /_____
MM/DD/YYYY

Group #: KQSA

Employee Date of Birth: _____ /_____ /_____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor:

Please fill in the information requested for the injured worker.

Employee Information

_____ ____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

CRP1806_0245 EME46657 OT48016Y

Workers' Compensation Temporary Prescription ID Card

myMatrixx
by Envarith

Participating Retail Network Pharmacies

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

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Medical Communications Authorization

I unconditionally authorize all medical doctors, licensed physicians, medical practitioners, surgeons, doctors of osteopathy, chiropractors, any medical-related facilities, insurance companies, other organizations, corporations, institutions, or persons that have any records, knowledge or information, including my mental or physical health, history, condition or welfare, to supply all such information to my employer and its insurers, including United Heartland, Accident Fund Insurance Company of America, their third-party claims administrators, attorneys, consultants, nurses and vendors which may participate in the evaluation and recruitment of information to determine my entitlement to benefits under any workers- compensation or occupational disease acts, or in the coordination of medical or vocational rehabilitation. This authorization includes, but is not limited to, the furnishing and delivery of reproduced or photographic copies of notes, reports, records, intake form and films.

I expressly authorize any treating physician or other medical care provider to communicate orally or in writing with the above-described entities regarding my past, present and future care and treatment, and to any other issues including but not limited to my diagnosis, prognosis, the causal connection of any injury or condition of ill being to my employment, treatment plan, nature and extent of injury, and my ability to work. I hereby waive any doctor-patient privilege resulting from any consultation, examination or treatment with or by you, and any relevant regulations under the Health Insurance Portability & Accountability Act. In addition, any treating physician or medical provider is authorized to review and discuss any additional records, films or information provided to them.

I understand that the persons, organizations or above-referenced entities that I am authorizing to share and communicate my information to may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits based on my decision to sign this authorization. I know that federal law may not protect my information once it is disclosed, and that my information may be shared with someone else after it is disclosed. I understand I have the right to rescind this authorization at any time, and that revocation of this authorization must be made in writing. I know that any communications or actions made prior to the revocation of this authorization will not be impacted by a revocation.

A photocopy of this authorization shall be as valid as the original. This release will remain valid for the duration of my workers' compensation or occupational disease claim, unless expressly rescinded in writing. I understand that after signing this authorization, I will be provided with a copy of it.

I have read and understand the information contained in this medical and communications release.

Social Security Number: _____ Date of Birth: _____

Signature: _____ Date: _____

Print Name: _____

Address: _____

_____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Supervisor Accident Investigation

Employee Name: _____ **Phone #:** _____
Accident Occur on Premises: ☐ Yes ☐ No Detailed Location: _____
Date of Injury: _____ Time: _____ ☐ am ☐ pm Shift: _____
Date Reported: _____ **Witnesses:** _____

Describe the accident in detail/what happened: _____

What object or substance directly harmed the employee: _____

Immediate Care: ☐ None ☐ First Aid ☐ Medical Clinic ☐ Emergency Room ☐ Medical Provider: _____

Supervisor Comments: _____

Root Cause Analysis

	No controls in place to eliminate or reduce the hazard. Ex: Lack of guarding, procedures, PPE, policies, proper tools/equipment, etc.
	Controls are not effective to eliminate or reduce the hazard (this includes a situation where an employee followed the policy and was still injured) Ex: Guards do not protect worker, poor housekeeping, improper tools for the job, policy or procedure not appropriate, etc.
	Training not provided or effective in preventing incident Ex: Job not understood.
	Lack of accountability, policy is not enforced or followed by management. Ex: Supervisors do not enforce rules or procedures.
	Employee chose not to follow the policy. Ex: Misconduct, horseplay, failure to obey rules, distracted,

Corrective Actions	Completion Date/Planned Completion Date
1	
2	
3	
4	
5	

Person(s) responsible for corrective actions: _____
Signature of person responsible for corrective actions: _____ **Date:** _____
Supervisor's Signature: _____ **Date:** _____
Manager Signature: _____ Date: _____

Witness Report of Incident

Name: _____ Job Title: _____
Address: _____ Phone: _____
_____ DOB: _____
Date of Hire: _____ Other Witnesses: _____
Date of Injury: _____ Time of Accident: _____ ☐ AM ☐ PM

Describe in detail what you observed: _____

What was your location relative to the employee you witnessed get injured: _____

What tools and/or equipment were involved in the accident: _____

Signed: _____ Date: _____

Modified Duty Work Agreement

For use when employee is released for work with restrictions.

[*Company Name*]

You are responsible for knowing your restrictions and limitations and expected to be aware of them at all times.

Never attempt tasks that exceed your restrictions and limitations. If a question exists with regard to assigned tasks or restrictions, advise your supervisor immediately.

Remember the medical restrictions are in effect 24 hours per day. Always exercise caution in your personal time to see that the restrictions are maintained. If you have hobbies or other outside interests, consult with the treating physician on possible effects.

Please include the following information:

1. List the medical restrictions submitted by employee's doctor or attach work status form.

2. Describe the modified work employee will do for the duration of this agreement.

Name of Employee (please print)

Name of Supervisor (please print)

Signature of Employee

Signature of Supervisor

Date

Date

Modified Duty Work Schedule

Week of:	My Restrictions are:
Employee Name:	My Symptom Control Techniques are:
Supervisor:	

Date	Hours Worked Log Breaks/Lunch	Primary Tasks & Duties	Employee Comments & Signature	Supervisor Comments & Signature
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

I clearly understand, take responsibility for and acknowledge the limitations my medical provider, Dr. _____ , has placed on me while participating in my company's Modified Duty Program.

_____ _____

Employee Signature Date