

Workers' Compensation

Employee

Forms



EMPLOYEE'S REPORT OF INJURY

We have received a report that you were injured in the course of your employment. To process your claim efficiently, please fill in all lines completely. **Attach additional sheets if necessary.** Email the completed report to rms@unt.edu using '#secure' in the subject line to securely send the email. If you have questions, call (940) 565-2109.

Name: _____ <small style="display: block; text-align: center;">Last First MI Maiden</small> Address: _____ City: _____ State: _____ Zip: _____ Primary Phone Number: _____ Secondary Phone Number: _____ Email address: _____	Social Security: _____ Gender: M F Date of Injury: _____ Time: _____ AM PM Employer: _____ Job Title: _____ Work Schedule: _____
1) What was the exact location of the accident (street address if possible):	
2) What was happening at the time? (What was going on around you, what were you doing, what were other people doing)	
3) Briefly describe what exactly caused the injury:	
4) What areas of your body were injured?	
5) When and to whom did you report your injury? Date _____ Time _____ AM PM Name: _____ Title _____ Phone Number: _____	
6) List all known witnesses. (Continue on back if necessary) Name _____ Phone: _____ Name _____ Phone: _____ Name: _____ Phone: _____	
7) Please identify your Primary Care Physician or family doctor: Name: _____ Phone: _____	
8) Please list the names and phone numbers of all doctors or treatment providers you have seen for your injury: Name: _____ Phone: _____ Name: _____ Phone: _____ Name: _____ Phone: _____	
9) Has a doctor taken you off work? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when was the first day you missed work ? _____	
10) If the doctor took you off work, have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, when do you think you will return to work? _____	
11) Date of Last Appointment: _____ 11) Date of Next Appointment: _____	
12) Have you had previous workers compensation injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please enter dates of injuries and the body parts injured.	
By affixing my signature, I attest that all information on this form is accurate and true.	
Signature: _____ Date: _____	



AUTHORIZATION FOR RELEASE OF INFORMATION

Patient: _____

TO WHOM IT MAY CONCERN:

You are hereby expressly authorized to release and furnish to the State Office of Risk Management (SORM), and/or any associate, assistant, representative, agent, or employee thereof, any and all desired information (including, but not limited to, office records, medical reports, memos, hospital records, laboratory reports, including results of any and all tests including alcohol and/or drug tests, X-rays, X-ray reports, including copies thereof) pertaining to the physical and/or mental condition which is the basis of my workers' compensation claim. This includes not only all current and/or future information but also all past medical information which is related to the injury or injuries which form the basis of my claim.

(Print name) _____

Photostatic copies of this signed authorization will be considered as valid as the original.

This is not a release of claims for damages.

SIGNED: _____ DATED: _____

PLEASE SIGN THE ABOVE MEDICAL AUTHORIZATION AND RETURN IT, SO WE MAY SECURE RELEASE OF YOUR MEDICAL RECORDS.

THANK YOU.

STATE OFFICE *of* RISK MANAGEMENT

Instructions Employee's Election Regarding Utilization of Sick and Annual Leave

Injured employees may elect to use accrued sick leave and all, part, or none of their accrued annual leave for time missed from work due to the work related injury. Accrued sick leave and accrued annual leave are the amounts of paid leave available at the time of injury in addition to leave earned after the injury. The following details the effects of the different choices available to you.

If You Choose Election 1

- You must use all accrued sick leave but may elect to use all, some, or none of your accrued annual leave.
- All sick leave must be exhausted before annual leave may be used.
- If you select 1A and return to work but later have additional days of disability, you must use any accrued sick and annual leave before receiving workers' compensation income benefits.
- If you select 1B, you must use any sick leave balance and any authorized annual leave before you will be eligible to receive workers' compensation income benefits.
- If you select 1C, you must use any/all accrued sick leave before receiving workers' compensation income benefits.
- Workers' compensation income benefits do not begin until the eighth day of disability. Employees who are disabled for at least 14 days will receive retroactive benefits for any portion of the seven-day waiting period not paid by leave.
- You will continue to receive your full pay as long as you have accrued time to use and have authorized your agency to use it for your injury. If your elected leave is exhausted, you may receive income benefits to replace a portion of your lost wages. This may be 70% or 75% of your average weekly wage depending on your wages at the time of your injury.
- It is recommended that you consult with your Human Resources Department to discuss the impact of your selection on your leave balances and insurance benefits should you be off work for an extended period of time.

If You Choose Election 2

- You choose to not use any sick or annual leave for your compensable injury. Your agency may immediately place you in a leave without pay status.
- You may not receive any workers' compensation income benefits for the first seven (7) calendar days you are unable to work. If eligible, your income replacement benefits will begin on the 8th day of disability and employees who are unable to work for 14 days will receive retroactive benefits for the first seven days. You will be paid at a rate of 70 or 75% of your weekly wage depending on your wages at the time of your injury.

Notice: With few exceptions, an individual is entitled, upon request, to be informed about the information a state governmental body collects about the individual. Under Sections 552.021 and 552.023 of the Government Code the individual is entitled to receive and review the information and under Section 559.004 of the Government Code the individual is entitled to have the state governmental body correct any information about the individual that is incorrect.



EMPLOYEE'S ELECTION REGARDING UTILIZATION OF SICK AND ANNUAL LEAVE

Employee's Name _____

Date of Injury _____

Employee's SSN _____

Agency _____

You are not required to use your leave. Texas Labor Code §501.044 allows an injured state employee to *elect* to use accrued sick and annual leave before receiving income benefits. Sick leave must be exhausted before annual leave may be used. Other categories of leave (compensatory leave, holiday leave, administrative leave, etc) may not be used prior to sick and annual leave.

Select only ONE election from the first two elections by initialing your choice. Monthly TIB election does not affect your other election.

ELECTION 1 (*must choose A, B, or C*) **Sick leave must be exhausted before annual leave may be used**

When I lose time from work due to this injury or illness, I elect to use all of my accrued sick leave **AND**:

- A.** All of my accrued annual leave.
- B.** A portion of my accrued annual leave (*enter number of hours: _____*).
- C.** None of my accrued annual leave.

Available Hours: Sick _____ Annual _____

ELECTION 2

- When I lose time from work due to this injury or illness, I elect to **not** use any accrued sick leave or annual leave. I understand I am not entitled to workers' compensation income benefits until after the seven (7) calendar day waiting period.

MONTHLY TIB ELECTION

- I elect to change my Temporary Income Benefits frequency from weekly to monthly.

I understand that I may not change my election after my eighth (8th) day of disability and signing this form. I have read the reverse side of this form,

Employee's Signature Date

Coordinator's Signature Date

Workers' Compensation Claim Acknowledgement

Fraud

Workers' compensation benefits are provided for employees who sustain a compensable injury or illness while performing duties within the course and scope of employment. Fraud occurs when a person **knowingly or intentionally conceals, misrepresents, or makes a false statement to obtain workers' compensation benefits.** An employee who files a fraudulent claim may be responsible for reimbursing all benefits paid on the employee's behalf. In addition, the employee may be subject to disciplinary action up to and including termination. **Fraudulent acts are also punishable in accordance with Texas state laws.**

Reporting Employment and Income

An employee receiving workers' compensation income benefits must report any employment or income earned to a UNT Risk Management Services (RMS) workers' compensation coordinator and the State Office of Risk Management (SORM) claims adjuster.

Treatment at UNT Student Health and Wellness Center

An employee who is injured while working may be treated at the UNT Student Health and Wellness Center (SHWC) for minor injuries. **Treatment at the SHWC must be approved in advance of visit by a RMS workers' compensation coordinator.**

Claim Compensability

If a claim is denied by the workers' compensation carrier, the employee may be held responsible for any expenses incurred.

Workers' Compensation Health Care Network

An employee who is injured while working and is not treated at the SHWC or does not require emergency room treatment must be treated by a provider in the **IMO HealthCare Network** to be eligible for workers' compensation medical benefits. Information about this network and providers is included in this packet. **Treatment by an IMO HealthCare Network provider must be approved in advance of visit by a RMS workers' compensation coordinator. If an employee chooses to be treated by a provider outside this network, they may be responsible for any charges incurred.**

By signing below, I certify that I have read and understand all the above information.

Printed Name

Signature

Date



- Attention Participating Network Employee**
- Show this card to each and every medical provider that treats you for your work-related injury.
 - With the exception of emergency medical care, you must treat with a network provider.
 - This card is for information purposes only and does not guarantee coverage.
- Please contact IMO at 888.466.6381 with any questions.



WORKERS' COMPENSATION IDENTIFICATION CARD



FOR WORKERS' COMPENSATION HEALTH CARE NETWORK ONLY

- Attention Provider**
- With the exception of emergency and initial medical treatment, you are required to notify the network of all referrals.
 - You must also be an approved network provider.
 - Contact the IMO Med-Select Network® to verify if you are an approved provider, or with questions regarding medical services.

IMO Contact Information:
 Phone: 888.466.6381, Fax: 877.946.6638
 Email: netcare@injurymanagement.com

Send Medical Bill to:
 State Office of Risk Management, PO Box 13777, Austin, TX 78711



✂ Cut here

**THE STATE OFFICE OF RISK MANAGEMENT
WORKERS' COMPENSATION PRESCRIPTION INFORMATION**

Employer:

Please complete the employee information below and provide the employee with this document to take with their prescriptions to any pharmacy.

Employee Name:	
Group#:	10602772
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	014211

**Day supply is limited to 30 days for a new injury
myMatrixx Help Desk: (877) 804-4900**

Employee:

The State Office of Risk Management has partnered with **myMatrixx** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 64,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist:

Please obtain above information from the injured employee, if not already filled in by employer, to process prescriptions for the workers' compensation injury only.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900



Notice of Network Requirements

Important Medical Care Information for Work-Related Injuries and Illnesses:

1. Effective September 1, 2014, your employer is partnering with IMO Med-Select Network[®] a certified Texas workers' compensation health care network. You are covered by the Network if you live in any of the counties listed below.
2. For any questions you may contact IMO by:
 - a. Calling IMO Med-Select Network[®] at 888.466.6381
 - b. Writing to P.O. Box 118577, Carrollton, TX 75011
 - c. E-mailing questions to netcare@injurymanagement.com
3. Each certified workers' compensation network must have one or more service areas where doctors and other health care workers are available to treat you if you are hurt on the job. The IMO Med-Select Network[®] service areas include the following counties:

Atascosa	Austin	Bandera	Bastrop
Bell	Bexar	Blanco	Brazoria
Burleson	Burnet	Caldwell	Cameron
Chambers	Colorado	Collin	Comal
Dallas	Denton	El Paso	Ellis
Fayette	Fort Bend	Galveston	Gonzales
Grayson	Guadalupe	Harris	Hays
Henderson	Hidalgo	Hill	Hood
Hunt	Johnson	Karnes	Kaufman
Kendall	Lee	Liberty	Medina
Montgomery	Navarro	Parker	Rains
Rockwall	San Jacinto	Smith	Starr
Tarrant	Travis	Van Zandt	Waller
Washington	Wharton	Williamson	Wilson
Wise	Wood		

4. A map of the service area with the above counties can also be viewed on the IMO website at www.injurymanagement.com or on page 9 of this packet.
5. Except for emergencies, if you are hurt at work and live in the network service area, you must choose a treating doctor from the list of network doctors. All services and referrals are to be received from your treating doctor.
6. You have the right to select your HMO primary care physician (PCP) as your treating doctor if your HMO PCP was selected prior to your injury at work. The network prefers that you make this decision as soon as possible. Your HMO PCP must agree to abide by the workers' compensation health care network's contract and rules.
7. Except for emergencies, the network must arrange for services, including referrals to specialists, to be accessible to you on a timely basis and within the time appropriate to the circumstances and your condition, but no later than 21 days after the date of the request.
8. If you need emergency care, you may go anywhere. If you become injured after business hours and it is not an emergency, go to the closest health care facility.
9. If you cannot contact your treating doctor after business hours, and you are in need of urgent care, go to the closest urgent care facility.
10. If you do not live in a network service area, you are not required to receive care from network providers.
11. If you are hurt at work and you do not believe you live within the network service area, call the State Office of Risk Management (SORM) at 877-445-0006. SORM must review the information within seven calendar days and notify you of their decision in writing.
12. SORM may agree that you do not live in the network service area. If you receive care from an out-of-network provider, and it is later determined that you live in the network service area, you may be required to pay the bill for health care services.
13. If you disagree with SORM's decision in regards to the network service area, you may file a complaint with the Texas Department of Insurance. Complaint form information is addressed in #27.
14. Even if you believe you do not live in the network service area, you still may receive health care from network doctors and other network health care staff while your complaint is reviewed by SORM and the Texas Department of Insurance.
15. SORM will pay for services provided by the network treating doctor and other network health care providers. Except for emergency care, you may be required to pay the bill if you get care from someone other than a network doctor without approval.

16. All network doctors and other providers will bill SORM for medical services related to your compensable work injury. The employee should not be billed by the network provider. Unless there is an emergency need, the network must approve any of the following health care services before they are provided to you:

- a. Admission to a hospital
- b. Physical therapy/occupational therapy, beyond allowable sessions
- c. Chiropractic care, beyond allowable sessions
- d. Any type of surgery
- e. Some initial and repeat diagnostic testing
- f. Certain injections
- g. All work hardening or work conditioning programs
- h. Equipment that costs more than \$1,000
- i. Any investigational or experimental services or devices
- j. Any treatment, service, medication, diagnostic test, or durable medical equipment that falls outside of, or not recommended by, any one of the following Evidence Based Guidelines: i) Official Disability Guidelines; ii) American College of Occupational and Environmental Medicine; iii) Medical Disability Advisor
- k. Mental health care
- l. All chronic pain programs

17. "Adverse Determination" means a determination, made through utilization review or retrospective review, that the health care services furnished or proposed to be furnished to an employee are *not* medically necessary or appropriate.

18. If the proposed health care services are for concurrent hospitalization, the person performing utilization review must, within 24 hours of receipt of the request, transmit a determination indicating whether the proposed services are pre-authorized. For all other requests for preauthorization, the person performing utilization review must issue and transmit the determination no later than three business days after the date the request is received.

19. If the network issues an adverse determination of the request for health care services, you, a person acting on your behalf, or your doctor may file a request for reconsideration by writing a letter or calling the network. Even though you can request a reconsideration of the denial yourself, the network encourages you to talk to your doctor about *filing* the reconsideration. He or she may have to send medical information to the network. This reconsideration must be submitted within 30 days of the date that your doctor receives the adverse determination in writing.

20. The network will respond to the reconsideration request within five business days of receipt demonstrating that the network has received the information. The network has up to 30 business days for the final determination. If it is a reconsideration request for concurrent review, the network will respond within three business days. The network will respond within one business day if it is a reconsideration request which involves a denial of proposed health care services involving post-stabilization treatment, life-threatening conditions or for continued length of stay in a facility.

21. Independent Review Organization (IRO) exemption: An employee with a life-threatening condition is entitled to an immediate review by an IRO and is *not* required to comply with the procedures for a reconsideration of an adverse determination.

22. If the network renders an adverse determination on a reconsideration of the following: i) a preauthorization review, ii) a concurrent review or iii) a retrospective review, the notification will include information on how to request an IRO. Requests for an IRO must be sent no later than 45 days from the date of the denial of the reconsideration.

23. If the situation is life threatening, you do not have to go through the network reconsideration process. You, the person acting on your behalf, or the requesting provider may request a review by an IRO. IRO requests shall be made to the Texas Department of Insurance on behalf of the patient by the Utilization Review Agent (URA).

24. An IRO review may be requested for several other reasons besides a life-threatening situation. The reasons may include: i) if the network denies the health care a second time by denying your reconsideration; ii) if the network denies the referral made by your treating doctor because it is not medically necessary, or iii) if the network denies your care because it is not within treatment guidelines.

25. After the review by the IRO, they will send a letter explaining their decisions. SORM will pay the IRO fees.

26. Your treating doctor may decide to leave the network. If so, and if it may harm you to immediately stop the doctor's care, SORM must pay your treating doctor for up to 90 days of continued care.

27. If you are dissatisfied with any part of the network, you can file a complaint. Any complaint must be filed within 90 days of the event with which you are dissatisfied. When a complaint is received, you will be sent a notification letter within seven days, which will describe the complaint procedures. The network will review and resolve the complaint within 30 days of receipt. *You can contact the network by:*

- a. Calling: 877.870.0638
- b. Writing: IMO Med-Select Network®
Attention: NetComplaint Dept.
P.O. Box 118577
Carrollton, TX 75011
- c. E-mailing: netcomplaint@injurymanagement.com

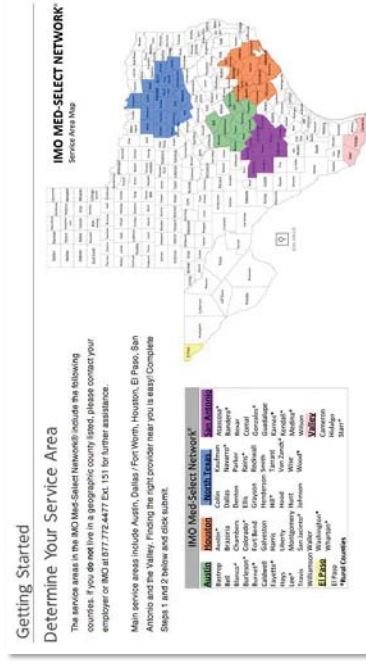
28. The network will not retaliate if:

- a. An employee or employer files a complaint against the network, or appeals a decision of the network, or
- b. A provider, on behalf of the employee, files a complaint against the network or appeals a decision of the network.



Find a Provider Search Instructions
www.injurymanagement.com

The snapshots below show samples of the following: **1)** A visual of the website homepage where the “Find a Provider” search can be easily located on the blue bar across the middle or under the “Services” tab; **2)** A visual of the page where the “Find a Provider” search and database are located; **3)** Step 1 and 2 of the search process; **4)** Search results format based on a sample zip code.



29. If you file a complaint with the network and are dissatisfied with the network resolution, you may file an appeal with the Texas Department of Insurance (TDI). *You can receive a complaint form from:*

- a. The TDI website at www.tdi.texas.gov, or
- b. Write to TDI at the following address:
Texas Department of Insurance
 HMO Division, Mail Code 103-6A
 P.O. Box 149104
 Austin, TX 78714-9104

30. Within five business days, the network will send a letter confirming they received the appeal.

31. A list of network providers will be updated every three months, including:

- a. The names and addresses of network providers grouped by specialty. Treating doctors shall be identified and listed separately from specialists; and
- b. Providers who are authorized to assess maximum medical improvement and render impairment ratings shall be clearly identified.

32. You can view, print, or email a provider directory online at www.injurymanagement.com.

Step 1: Define Your Search

One or more of the following can be used to define your search.

Define Your Search

Enter Your Zip Code: To search by multiple zip codes, insert a comma OR space in between each.

Tell Us Your Preferred Distance: Less than 5 Miles 15 Miles 30 Miles 60 Miles 75 Miles

Search by Practice / Facility Name: Search by Provider Tax ID Number:

Search by Provider Last Name: Search by City Name:

Step 2: Choose Your Provider Type

Select the provider type you want to search and use the dropdown menus to best narrow your criteria.

Choose Your Provider Type

The IMO Med-Select Network requires your **treating doctor** to be a physician chosen from the network directory and who is a licensed Medical Doctor (MD) or Doctor of Osteopathy (DO). Treating doctors' primary service **must** be one of the following: Family Practice / Family Medicine, General Practice / General Medicine, Occupational Medicine, Internal Medicine or Physical Medicine or Physical Rehabilitation (in ET Paso only).

Treating Doctors

Specialists / Facilities

MMI / IR Physicians

All Providers

Review Search Results

After Steps 1 and 2 are submitted, you will see the below information shown in this sample snapshot including the option to print and email the list, in addition to Google Map directions if desired.

To view the "ProviderDetails" page, click on the "Practice / FacilityName" in red you wish to see.

For further questions, please contact the IMO Med-Select Network at 888.466.6381.