Risk Management

Marjorie Kenol
7-0341

Workers' Compensation

UPDATED CLAIM REPORTING STEPS

- 1st step - NEW FORM:

"Employee's Report of Injury Form"

Handwritten form to be completed and signed by the injured employee.

Documents/memorializes the occurrence in employee's words.

A tool for the office manager to use for the electronic claim submission.

Similar purpose to an incident report/standard WC step.

Facilitates accurate and efficient claim-handling.

EMPLOYEE'S REPORT OF INJURY FORM

Instructions: Employees shall report all work-related accidents and injuries using this form, regardless of how minor, on the date injury or as soon as reasonably possible even if the employee does not wish to seek treatment.

YOUR NAME	YOUR PHONE NUMBER	EMPLOYEE ID

JOB TITLE	SUPERVISOR'S NAME	DATE OF THIS REPORT

INCIDENT DETAILS

LOCATION OF OCCURRENCE	DATE OF INCIDENT	TIME OF INCIDENT

WITNESSES

INCIDENT DESCRIPTION: Describe tasks being performed and sequence of events. Attach additional pages as needed.

WHAT SPECIFIC BODY PART WAS INJURED?

IS MEDICAL TREATMENT NECESSARY? YES ☐ NO ☐ HAS THIS BODY PART BEEN INJURED BEFORE? YES ☐ NO ☐

IF YES, WHEN? _____ HOW_____

WHAT PHYSICIAN TREATED THE PRIOR INJURY? _____

I CONFIRM THE ABOVE INFORMATION IS TRUE AND ACCURATE. I UNDERSTAND AS PART OF MY CLAIM SUBMISSION I AM REQUIRED TO COOPERATE AND COMPLY WITH WRITTEN AND VERBAL COMMUNICATION REQUESTS FROM THE DISTRICT'S THIRD PARTY ADMINISTRATOR, JOHNS EASTERN CO, INC. AND THE RISK MANAGER REGARDING THE HANDLING OF MY WORKERS' COMPENSATION CLAIM. I UNDERSTAND I AM REQUIRED TO SIGN THE STATE OF FLORIDA DWC-1 FORM AND MEDICAL AUTHORIZATION FORM, WHICH ARE PROVIDED TO ME UPON MY CLAIM SUBMISSION, TO FACILITATE THE HANDLING OF MY WORKERS' COMPENSATION CLAIM AND TO ALLOW, IF NECESSARY, AUTHORIZED PROVIDERS TO RETRIEVE SUCH PRIOR MEDICAL RECORDS WHICH MAY BE PERTINENT TO MY INJURY EVALUATION.

EMPLOYEE SIGNATURE	DATE	SUPERVISOR SIGNATURE	DATE

Workers' Compensation

UPDATED CLAIM REPORTING STEPS

- 2nd step – Electronic submission through Johns Eastern website

aka Electronic "First Report of Injury"

Contact Marjorie re: username issues. All usernames and passwords are pre-set. Username format should be "CCPS00##", not an individual's name. Each site has its own username. Designate one reliable backup person for claim entries in the event of your absence when an injury occurs. Office manager and the backup use the same site-specific username and password. Let your backup watch you enter a claim ahead of your absence.

Workers' Compensation

UPDATED CLAIM REPORTING STEPS

- 2nd step – Electronic submission through Johns Eastern website

aka Electronic "First Report of Injury"

Complete electronic entry with as much information as possible, and use the handwritten "Employee Report of Injury Form" as a tool to help you. Be sure to submit by clicking "Finish."

Workers' Compensation

UPDATED CLAIM REPORTING STEPS

- 2nd step – Electronic submission through Johns Eastern website

aka Electronic "First Report of Injury"

If the electronic entry is correctly submitted, the system will ask you if you want to print the "First Report of Injury" forms. Click, OK and print the pages of the forms. The four pages include DWC1 (FROI) and a Medical Authorization. GIVE THE INJURED EMPLOYEE ALL 4 PAGES TO COMPLETE ON-THE-SPOT. THIS IS VERY QUICK AND EASY.

Workers' Compensation

UPDATED CLAIM REPORTING STEPS

- 3rd step – Employee completes FROI and Medical Authorization

The employee needs to sign the 1st page [DWC1 (FROI)] and complete and sign the 3rd page (Medical Authorization).

IMPORTANT: Be sure the medical providers section (mid-section of 3rd pg) is completed. Please check for completion then make a copy.

Employee keeps a copy, and a copy must be returned to Marjorie right away.

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
01/04/2021		

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last): [redacted]

Social Security Number: [redacted]

Date of Accident (Month-Day-Year): [redacted]

Time of Accident: 10:40 ☒ AM ☐ PM

HOME ADDRESS
Street/Apt #: [redacted]
City: [redacted] State: FL Zip: [redacted]

TELEPHONE Area Code Number: [redacted]

EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)
Walking up to the staff dining sink employee fell on right knee.

OCCUPATION: [redacted]

INJURY/ILLNESS THAT OCCURRED: Contusion

PART OF BODY AFFECTED: Knee

DATE OF BIRTH: [redacted]

SEX: [redacted]

EMPLOYER INFORMATION

COMPANY NAME: Collier County Dist. School Board
D. B. A.:
Street: 5775 Osceola Trail
City: Naples State: FL Zip: 341090919

FEDERAL I.D. NUMBER (FEIN): 59-6000557

DATE FIRST REPORTED (Month/Day/Year): 01/04/2021

NATURE OF BUSINESS:

POLICY/MEMBER NUMBER:

TELEPHONE Area Code Number: [redacted]

DATE EMPLOYED: [redacted]

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: 1 / 4 / 2021

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: [redacted]
City: [redacted] State: FL Zip: [redacted]
COUNTY OF ACCIDENT:

DATE OF DEATH (If applicable): / / /

AGREE WITH DESCRIPTION OF ACCIDENT? ☒ YES ☐ NO

RATE OF PAY ☒ HR ☐ WK ☐ DAY ☐ MO
$ 14.9 PER
Number of hours per day: 8
Number of hours per week: 40
Number of days per week: 5

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
Pointe Medical Center (PMC)
870 111th AVE N
Naples, FL 34108

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 CODE #:

EMPLOYEE'S CLASS CODE: 9101

EMPLOYER'S NAICS CODE:

SERVICE CO/TPA CODE #: 6043

CLAIMS-HANDLING ENTITY FILE #:

INSURER NAME
Collier County Dist. School Board

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE
Johns Eastern Co., Inc.
P.O. Box 110279
Lakewood Ranch, FL 34211
1-800-749-3044

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.

JOHNS EASTERN
Claim Adjusters & Third Party Administrators

P.O. Box 110279
Lakewood Ranch, FL 34211
Tel: (941) 907-3100
Toll Free: 1-877-326-JECO
Fax: (813) 402-7922

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION:

Name (Print): [redacted] DOB [redacted] SSN [redacted]

Address: [redacted] Phone: [redacted]

Employer: Collier County Dist. School Board Claim No. DOA: [redacted]

INFORMATION TO BE RELEASED

✓ I authorize all physicians, medical providers and insurance companies to release any and all medical records for all dates of service to include medical reports and notes; lab reports and results; pathology reports and results; radiology reports/results; X-rays/Scans and pharmacy records.

INFORMATION TO BE RELEASED FROM

(Please list any and all physicians you have treated with in the past 10 years)

Name of Facility or Provider: Address:

INFORMATION TO BE RELEASED AND MAILED TO:

Johns Eastern Company
P.O. Box 110279
Lakewood Ranch, FL 34211
Phone: 1-800-749-3044

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE

The employee has an active Worker's Compensation Claim

****FRAUD STATEMENT****

Any person who, knowingly and with intent to injury, 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.

Employee Signature: _____ Date: _____

Employee Name: [redacted] Date of Birth: [redacted]

Healthesystems Injured Worker First Fill Prescription Form

Instructions for: Employer*

Please complete this form before providing to Injured Worker.

*Last Name, First Name: [redacted]	*Social Security Number: [redacted]
*Date of Injury: [redacted]	*Date of Birth: [redacted]
*Employer Name: Collier County Dist. School Board	

*Required Information

Instructions for: Injured Workers*

To fill your initial (first) prescriptions for a workers' compensation injury, follow these easy steps:

1. Present this form within 30 days of the date you were injured.
2. Locate a participating pharmacy closest to you. For assistance use the following tools:
   - Call: 1.800.758.5779
   - Visit: www.healthesystems.com and click on "Pharmacy Search" located under the "Pharmacy Tools button"
   - A sample listing of pharmacies are provided at the bottom of this form

*For new injuries only

Instructions for: Pharmacists

Your pharmacy has contracted to participate in the Healthesystems Pharmacy Network. To dispense the patient's first-fill for their workers' compensation prescription:

- Indicate that this is a new workers' comp injury; do not process under an existing injury
- Call the Healthesystems Customer Service Center: 1.800.758.5779
- Process using the Member ID # provided by Healthesystems

Prescription Processing Information:

Transmit prescription using the following

Healthesystems Customer Service Center phone number: **1.800.758.5779** (press 1 for retail pharmacy option)		
BIN: **012874**	Third Party Administrator: **Johns Eastern Company, Inc.**	* Member ID: *(provided by Healthesystems CSC representative)*

*Required Information

Healthesystems Pharmacy Network

Albertson's	Fred's Pharmacy	Long's Drug Store	Safeway Pharmacy	Vons Pharmacy
Bi-Lo Pharmacy	Giant Eagle	Medicap Pharmacy	Sam's Club	Walgreens
Brooks Pharmacy	Giant Pharmacy	Medicine Shoppe	Sav-On Drugs	Wal-Mart
Costco Pharmacy	HEB Pharmacy	Meijer Pharmacy	Shoprite Pharmacy	Winn Dixie Pharmacy
CVS Pharmacy	Hy-Vee Pharmacy	Osco Drug	Stop & Shop	
Duane Reade	Kmart	Publix Pharmacy	Target	
Eckerd Drug	Kroger Pharmacy	Rite Aid	VAMC	

Call 1.800.758.5779 or visit www.healthesystems.com to see a full list of network pharmacies.

Workers' Compensation

UPDATED CLAIM REPORTING STEPS

- 4th step – Returning the completed FROI and Medical Authorization

Email: scan and send to kenolm@collierschools.com

Use subject line: RISK MANAGEMENT: 1000000000 LW (EID and employee's first and last initials)

-OR-

Pony: Allow employee to seal their forms in an envelope, then place the sealed envelope in a pony envelope to Marjorie Kenol.

Workers' Compensation

UPDATED CLAIM REPORTING STEPS

- ADDITIONAL ITEMS:

1. Lost time communication
2. Light duty accommodations communication
3. Taking oneself out-of-work for an injury
4. Coding leave forms for work-related injury appointments
5. Acceptable appointment times

Property and Casualty

What to do when the unexpected happens

- Damage to school property by third parties

  Make a police report to YRD

  Email Marjorie facts of loss, date/time of loss, description of damages, police report #, security camera #s, responsible party's name/contact information/insurance information, if applicable

Risk Management

Questions?

Thank you for your time!