Warren County Self-Insurance

Workers' Compensation

Claim Reporting Checklist for <u>EMPLOYERS</u>

Step 1: Call **518-761-6528** or email **claims@warrencountyny.gov** to report the claim as soon as the any member of management knows about it.

Step 2: Give the employee the claim packet and make sure to get it back as soon as possible to meet the 10-day filing requirement.

Before submitting claim documents to Warren County Self-Insurance, check that you have completed the steps below:

- ✓ Employee injury report has been completed and signed by the employee
- ✓ Employee has completed and signed the Authorization to Obtain Information
- ✓ The employee's supervisor has completed and signed the Supervisor's report
- ✓ C2-F has been completed in entirety
- ✓ Double check that all fields are completed on the C2-F
- ✓ Email all to claims@warrencountyny.gov no later than 10 days after injury date

Additional tasks if the employee is <u>out of work</u> due to the injury:

- Email claims@warrencountyny.gov that the employee is out of work and advise if the employee will be using leave time or will be off payroll
- Complete C-240 form and send with the forms above

<u>If you don't have all forms ready to send within 10 days, contact the Self-Insurance Plan at 518-761-6528.</u>

Warren County Self-Insurance

Employer Duties When Employees are Injured at Work

When injury occurs

Employer must report injuries to Warren County Self-Insurance IMMEDIATELY by calling 518-761-6528 or by emailing claims@warrencountyny.gov. Report any information that is available, including name of employee, phone, injury description, type of medical care, lost time expected. Employers are deemed "notified" of an injury when the employees supervisor knows. This is the start of the countdown for all reports.

Within 10 days of injury

Employer must send claim forms regarding the injury to Warren County Self-Insurance within 10 days. Penalties for late filing will be assessed if claim documents are not timely. Claims can be emailed to claims@warrencountyny.gov

If the employee has missed time from work, employer must file C240 form and contact Warren County Self-Insurance to advise if the employee is using leave time or is off of the payroll.

Within 18 days of injury

Warren County Self-Insurance must ensure that payment is being made to the injured worker and file appropriate forms with the Workers' Compensation Board. Warren County must have accurate information from the Employer to do this. Penalties are assessed to the Employer for tardiness.

When the employee returns to work

The Employer must share information with Warren County Self-Insurance immediately upon the employee's return to work. Employer must file C-11 form. If the employee used leave credits, employer must also file Reimbursement Request form.

Whenever an employee is out of work

Keep in regular contact with the injured worker. Request out of work notes to cover any time that they will not be at work. Share out of work information with Warren County Self-Insurance.

All forms and information can be sent to claims@warrencountyny.gov.
Questions: call 518-761-6528, 518-761-6529, or 518-824-6610.
We are here to help you!

Super fill out & return to Kelly

SUPERVISORS REPORT OF INCIDENT INVESTIGATION

This form is to be used to determine the root cause of an incident and how a similar incident can be prevented in the future. Supervisors should complete this form for every incident involving employee injury or near miss. Please print.

Employee Injured:____________________________ **Date of incident:**__________ **Time:**__________

What was the task or job just before the incident occurred, include who was on site or involved? (i.e. Employees John & Tom were replacing a culvert at 123 Route 5 Whooville)

What was the incident? (While Tom was lifting the culvert with the loader the chain broke and culvert fell on John)

When did you know about the incident?

What body parts did the employee injure and to what extent? (Be specific, i.e. bruised right leg below knee)

Was there any damage to property or equipment? (Note: auto & property damage may require additional forms.)

What was the ROOT cause(s) of the incident? (ask "why" until root cause(s) is determined)

Was the incident preventable?
What actions will / should be taken to eliminate future repeats of the incident? (i.e. training, use PPE, other equipment)

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Signature:____ Date:______________

Employee fills out & Return to Kelli

EMPLOYEE INJURY REPORT

This form should be completed by any employee that has sustained a work related injury and is seeking medical treatment or will miss time from work due to injury.

PLEASE PRINT CLEARLY

Employee Name:______________________________ Date of Birth: ____________ Phone:__________

Employee Address:____

Last 4 digits of Social Security #: xxx-xx-________ What municipality do you work for?______________________

DATE OF INJURY: ______________ Time of injury: ______ am pm Time you began work that day: _______ am pm

Where were you working when the injury happened?

What were you doing when you got injured and how did the injury happen?

Explain fully the nature of your injury; list body parts affected and if right or left:

Are you going to seek medical attention for this injury? _____ If so, where? ______________________

Are you out of work due to this injury? _______ If so, what date did you stop working?_______________

When do you expect to return to work?_______________

How could this incident have been prevented?

Did anyone witness the injury?_____
If so, please list names:____

Have you ever injured the same body part before, at work or at home?______ If so, give details below:

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employees Signature:____ Date:_______________

Please give this form to your immediate supervisor as soon as possible.

Employee to sign & Return to Kelli

AUTHORIZATION TO OBTAIN INFORMATION

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize Warren County Self-Insurance to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Person(s) / organizations authorized to use or disclose the information:

   Any medical facility that has treated me in the past.

2. Person(s) / organization to whom the requested use or disclosure may be made:

   Warren County Self-Insurance and/or its agents.

3. Specific description of information that may be used or disclosed:

   Copies of medical records including, but not limited to, patient questionnaires, patient intake sheets, referral forms, patient history forms, office notes, reports, charts, x-ray or other films, etc., and/or copies of hospital and medical records relating to services rendered to me for the following medical condition(s):

   Any condition except those excluded below.

   Excluding (1) any and all confidential HIV and AIDS related information protected under Article 27-F of the New York Public Health Law and (2) any and all confidential mental health records protected under Section33.13 of the New York Mental Hygiene Law.

4. Purpose of the requested use or disclosure:

   For the use in a pending Workers' Compensation claim brought by me.

5. I understand that I may revoke this authorization at any time by giving written notice to the person / organization that is providing the information I no longer want to be used or disclosed, except to the extent that action has already been taken in reliance on this authorization.

6. I understand that the medical provider may not condition the provision of health care services on whether I sign this authorization.

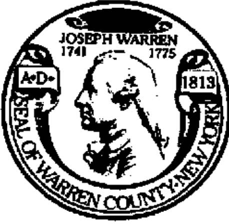
7. This authorization expires upon the final closure of the Workers' Compensation claim brought by the individual.

8. Photocopies and electronic copies of this authorization should be accepted as original.

Signature of Individual Authorizing Use/Disclosure	Date	Printed Name of Individual

For Office Use: Date of Injury:____________ Carrier Case #_____________ WCB#____________

Employee Info



Claimant Information Packet

WARREN COUNTY SELF-INSURANCE DEPARTMENT
1340 State Route 9 * Lake George NY 12845 * Phone 518-761-6528 * Fax 518-761-6249
Email: warrencountyinsurance@warrencountyny.gov

You were injured at work. What now?

If you've suffered a workplace injury or illness, you may be eligible for workers' compensation benefits. You may have already received medical treatment. If you haven't, you should seek the medical care that is necessary.

A Worker's Responsibilities

- You must tell your employer, in writing, when, where and how you were injured. Report injuries as soon as possible but always within 30 days of the injury.
- Medical reports are necessary for your case. Advise your doctors that you have a work-related injury, and give the name of your employer. Do not pay for your care yourself or use other health insurance. Tell your doctor to file reports with the NYS Workers' Compensation Board and with Warren County Self-Insurance, your employer's insurance carrier. Ask that your doctor complete the "Workers' Compensation Medical Visit Encounter Form" and fax it back to Warren County Self-Insurance. This may help expedite your claim. If your case is disputed, the Workers' Compensation Board needs a medical report on your injury to begin resolving your claim.

Starting a Case

Once your employer knows of your injury, they must notify the Warren County Self-Insurance Department by filing a C-2f form. You should file an "Employee Injury Report" form reporting your injury as soon as possible. You should complete the "Authorization to Obtain Information" and give it to your employer immediately.

Additionally, you may file a C-3 Employee Claim with the NYS Workers' Compensation Board, there are two ways to do it.

- Visit www.wcb.ny.gov to complete the form
- Call 1-877-632-4996. A Workers' Compensation Board employee will assist you.

Health Care Benefits

Do not pay your doctor or hospital. Those bills are paid by the insurer unless the Workers' Compensation Board disallows your case. If your case is disputed, the providers are paid when the Workers' Compensation Board decides your case. If the Workers' Compensation Board decides against you, or if you don't pursue a case, you will have to pay the doctor or hospital.

Warren County Self-Insurance covers medically necessary drugs and equipment that your doctor prescribes. You're also entitled to carfare or necessary expenses incurred when traveling for treatment. Make sure that you obtain receipts for those expenses, and submit them to Warren County Self-Insurance on a Claimants Record of Medical and Travel Expenses and request for Reimbursement (Form C257).

Employee Info

Generally, you can choose any health care provider authorized by the Workers' Compensation Board. You can search for an authorized provider on the Board website, wcb.ny.gov. Warren County participates in the ONECALL MEDICAL diagnostic radiology network, therefore if you require diagnostic radiology services (MRI, EMG, NCS, CT, Ultrasound, Bone Scan or Arthrograms) you or your physician must contact us before performing these tests. Additionally, Warren County participates in the AWPRx pharmacy benefits network. Therefore, pharmacy benefits must be obtained from an AWPRx network pharmacy.

Benefits for Lost Wages

You are entitled to a portion of your lost wages if your injury affects you in one or more ways:

1. It keeps you from work for more than seven days;
2. Part of your body is permanently disabled;
3. Your pay is reduced because you now work fewer hours or do other work.

You may hire an attorney or licensed representative, but it isn't required. The Workers' Compensation Board sets their fees, which will be deducted from your lost wages award. You should not pay anything directly to your attorney or licensed representative.

If your case is disputed, you may be eligible to receive short term disability benefits while the case is heard. Check with your employer about disability benefits and ask for a DB-450 claim form. If your case is resolved in your favor, the disability benefits would be deducted from your lost wages award.

Help is Available

Sometimes you need help getting back to work. An injury can also cause family or financial problems. The Workers' Compensation Board has vocational counselors and social workers to help. More information is also available on the NYS Workers' Compensation Board website at: wcb.ny.gov

What's Next?

Warren County Self-Insurance will send you information and documentation if your claim is accepted or denied. When the claim is accepted, your treatment will be paid and lost wages benefits begin. If your case is challenged, the Workers' Compensation Board will notify you about resolving the case and may request additional information if necessary.

Important Contact Information

Workers' Compensation Board	877-632-4996
Warren County Self-Insurance	518-761-6528

Employee take to Dr - - . Return to Kelli

Warren County Self-Insurance Department
1340 State Route 9, Lake George NY 12845
518-761-6528, Fax 761-6249, e-mail warrencountyinsurance@warrencountyny.gov

CC#________

Workers' Compensation Medical Visit Encounter Form

***To the Injured Worker:** Give one copy of this form to your physician/ chiropractor at each visit. (Call Self-Insurance for additional forms or duplicate this one.)*

Patient Name:________________________________

Date of Service:________________ Date of Birth:________________

In your opinion, is the disability arising out of and in the course of employment or occupational disease? Yes No

Date of injury:________________

Is the patient losing time from work? Yes / No First day of lost time:___/___/___

Can the patient return to work? Full duty / Modified duty _____/_____/_____

Modified duty requirements:____

Diagnosis:____

Prescriptions given to treat injury:____

Treatment Plan:____

Percentage of impairment (0-100%):__________% Temporary / Permanent

Apportionment? Yes No Pre-existing ________% Current injury________%

Next visit:___/___/___ Time:________ with Provider:____________________

Providers Signature:________________________________ Date:___/___/___

Print Providers Name:____

Facility Name:____

Please Fax this form immediately to: 518-761-6249
or email to warrencountyinsurance@warrencountyny.gov

Employee Info

The AWPRx pharmacy network is a national network that includes both national chains and local independent pharmacies. For a list of network pharmacies, please visit our website at www.awprx.com or call our customer service team for a list of network pharmacies in your area **888-700-0992**.

A&P
ACME PHARMACY
AHF PHARMACY
BARTELL DRUGS
BEL AIR PHARMACY
BIG Y PHARMACY
BI-MART PHARMACY
BROOKSHIRE BROTHERS
CITY MARKET PHARMACY
COBORNS PHARMACY
CONTINUCARE MEDICAL GROUP
COSTCO WHOLESALE
CVS PHARMACY
DIERBERGS
DISCOUNT DRUG MART
EMBLEMHEALTH SERVICES
ESSENTIA HEALTH
FAGEN PHARMACY
FARM FRESH PHARMACY
FARMACIAS PLAZA
FOOD CITY PHARMACY
FOOD LION PHARMACY
FRUTH PHARMACY
FRYS FOOD AND DRUG
GERBES PHARMACY
GIANT EAGLE PHARMACY
HAGGEN PHARMACY
HARRIS TEETER PHARMACY
HARTIG DRUG CO INC
HARVARD VANGUARD MEDICAL
ASSOCIATES PHAR
HARVEYS SUPERMARKET
HEALTHPARTNERS
HEB PHARMACY
HENRY FORD MEDICAL CENTER
HOUSECALLS PHARMACY
HY-VEE PHARMACY
KELSEY PHARMACY
KERR DRUG
KING KULLEN PHARMACY
KING SOOPERS PHARMACY
KINNEY DRUGS
KMART PHARMACY
KROGERS
LONESTAR RX
LOWELL COMMUNITY HEALTH
CENTER PHARMACY
MACEYS PHARMACY
MARCS PHARMACY
MARSH DRUGS
MARSHFIELD CLINIC SPECIALTY
MARTINS PHARMACY
MEDFAST PHARMACY
MEIJER PHARMACY
NAVARRO HEALTH SERVICES
OMNICARE
OSCO PHARMACY
PARADIS SHOP N SAVE
PATHMARK PHARMACY
PATIENT FIRST
PICK N SAVE PHARMACY
POSTAL PRESCRIPTION SERVICES
PRICE CHOPPER PHARMACY
PRICE CUTTER PHARMACY
PUBLIX PHARMACY
QFC
QOL MEDS
QUICK CHEK PHARMACY
RALEYS PHARMACY
RALPHS PHARMACY
REASORS PHARMACY
RITE AID PHARMACY
RITZMAN PHARMACY
ROY HARMONS APOTHECARY
RXAMERICA
SAFEWAY PHARMACY
SAFFA INFUSION PHARMACY
SARTORIS SUPER DRUGS
SAVE MART PHARMACY
SAVON PHARMACY
SCHNUCKS PHARMACY
SHOPKO STORE
SHOPPERS PHARMACY
SHOPRITE PHARMACY
SMITHS PHARMACY
ST JOHN SPECIALTY PHARMACY
STOP AND SHOP PHARMACY
SUN MART PHARMACY
SUPER ONE
TARGET STORES
TEXAS ONCOLOGY PHARMACY
TFHC23 PHARMACY
THE PHARMACY CENTER
TIMES PHARMACY
TIMPVIEW PHARMACY
TOPS PHARMACY
UNITED MEDICAL
UNITED PHARMACY
VANGUARD ADVANCED
PHARMACY SYSTEMS
VG'S PHARMACY
VILLAGE PHARMACY
VILLAGE SUPERMARKETS
VONS PHARMACY
WALDBAUMS PHARMACY
WALGREENS PHAMACY
WALMART PHARMACY
WEGMANS FOOD MARKETS
WEIS PHARMACY
WELLSPRING FAMILY MEDICINE
WHITE DRUG
WINN DIXIE PHARMACY

Employee in case of new Script

Temporary Prescription Form

Client Name: **Warren County**

1. Instructions for the **EMPLOYER:**

- Provide this form to your injured worker to have any prescription filled for a temporary **10 day supply,** and please fill out the information below:

Claimant Name: ______________________ **SSN:** ______________________
Claimant DOB: ______________ **Claimant's Home Phone #:** ______________
Claimant Employer: __________________ **Date of Injury:** ______________
Claimant Address: ____
City: ____________________________ **State:** __________ **Zip:** __________
Employer Representative: ________________________________ **Date:** __________

2. Instructions for the **INJURED WORKER:**

- **You, the injured worker will need to bring this form and provide it to the pharmacy along with your prescriptions related to the treatment of your work related injury/illness**

3. Instructions for the **PHARMACY:**

- Please submit workers' compensation claims to **AWPRX**
- **BIN** **610237**
- **PCN** **AWPRX**
- **Group ID** **AWPRx63**
- **ID number** **Use Social Security from the top of the form**
- Prescription(s) will fill for a **10 Day Supply**. If there is a remaining balance on the script after the **10 Day Supply** is filled, AWPRx will call back if and when the balance has been approved. If you need assistance, please call **AWPRx** at **888-700-0922**.

AWPRx office hours are Monday through Friday, 8:00AM EST to 8:00PM EST. We also have representative's on-call 24 hours/7 days a week.

FOR ALL REJECTIONS OR QUESTIONS CALL: (888)-700-0922

The Right Med. At The Right Time. At The Right Price.