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**

BE SURE TO:

- ✓ 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 chances 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.

EMPLOYEE'S INJURY REPORT

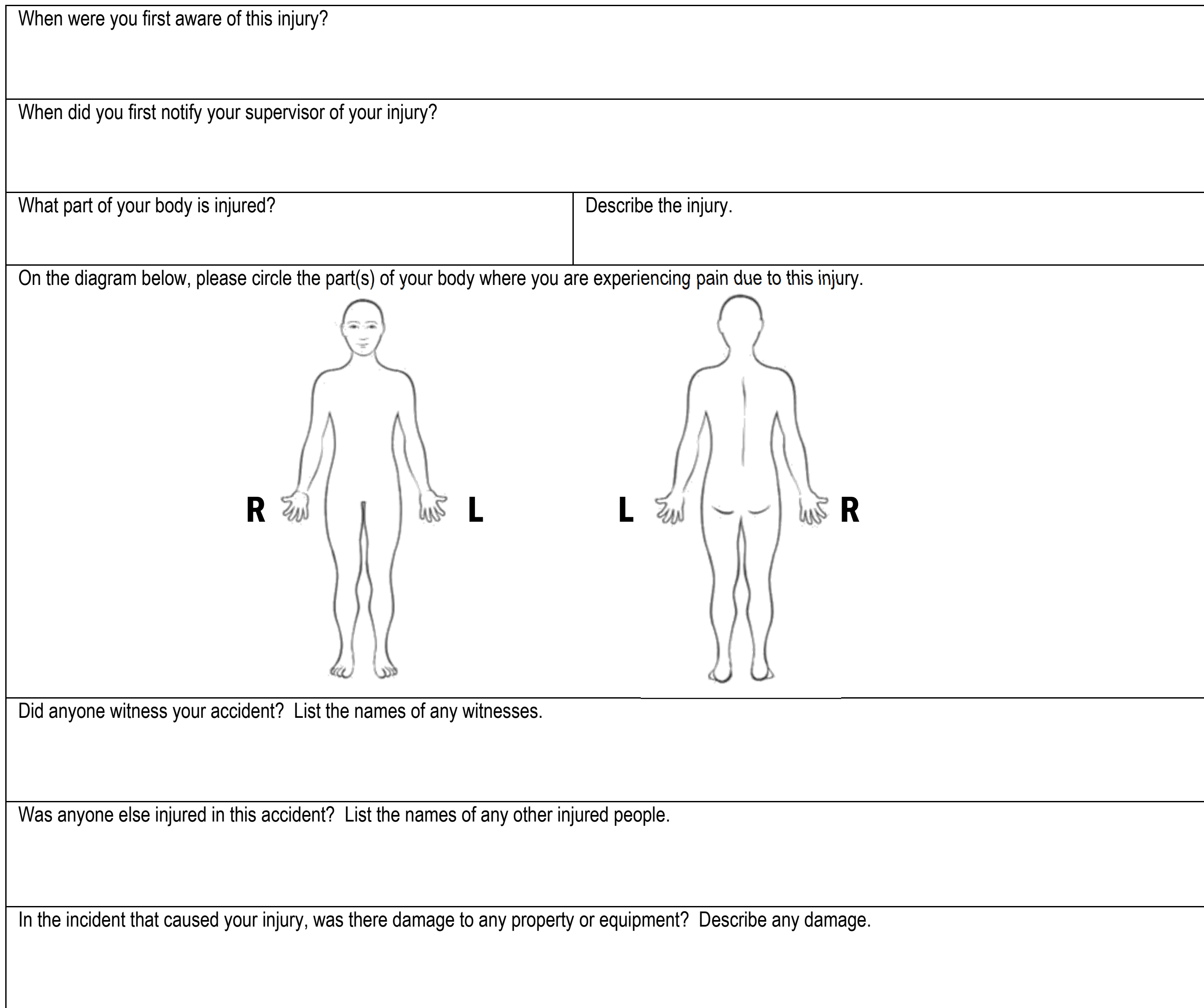
This form must be completed in detail and signed by the injured employee.

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?	
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, his agent or insurance company.**

Employee's Printed Name	Employee's Signature	Date

- ✓ **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 this date.**

Witness Printed Name	Witness Signature	Date

Supervisor's Printed Name	Supervisor's Signature	Date

HIPAA AUTHORIZATION FORM

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

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, diagnosis, tests, reports or treatments.**
   + **I further specifically authorize the disclosure of psychotherapy notes, if any.**
4. The purpose for 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 on 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 which 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.

Workers' Compensation Temporary Prescription ID Card

myMatrixx®
An Express Scripts Company

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed the processing of your approved workers' compensation prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx, an Express Scripts Company Customer Care at 877.804.4900.

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 a la Atención a Clientes en myMatrixx, una compañía de Express Scripts, al 877-804-4900.

Express Scripts

ID#: ______________________________

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 #: PAWA

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 Pharmacist:

myMatrixx, an Express Scripts Company administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 7-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, call myMatrixx, an Express Scripts Company Customer Care at 877.804.4900.

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 ID number

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

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

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

____

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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
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
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
Walmart
Wegmans
Weis
Winn Dixie

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Complete if known:

DWC Claim #

Insurance Carrier Claim #

Request to get reimbursed for travel costs

Este formulario está disponible en español en el sitio web de la División en
www.tdi.texas.gov/forms/dwc/dwc045brcs.pdf
Para obtener asistencia en español, llame a la División al 800-252-7031.

Filing instructions: Complete boxes 1-11 and sign the form. **Send it to the insurance carrier** within one year of when you incurred (charged) these costs. Keep a copy of the completed form and receipts. Do not send this form to the Division of Workers' Compensation (DWC).

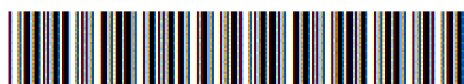
Part 1: Information about injured employee, employer, and insurance carrier

1. Employee name (First, Middle, Last)	**2. Date of injury** (mm/dd/yyyy)
3. Employee mailing address (Street or PO Box, City, State, ZIP Code)	
4. Employer (at time of injury)	**5. Employee phone number**
6. Insurance carrier name	**7. Insurance carrier fax #**

Part 2: Information about travel

8. Trips for medical treatment and exams more than 30 miles one way.

Date	Travel from (street address)	Travel to (health care provider's name **and** street address)	Miles driven (round trip)



9. Overnight stays and meals. Send receipts for these costs.

Date	Location	Meals	Hotel/lodging
		$	$
		$	$
		$	$
		$	$
		$	$
		$	$
		$	$
		$	$

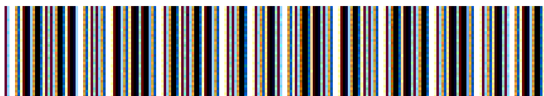
Part 3: Injured employee's statement

I certify the above information is correct and is for travel for treatment or an exam for my work-related injury.	
10. Sign here:	**11. Date:**

Part 4: Insurance carrier's response to injured employee's request to get reimbursed for travel costs

You must provide a plain language explanation of any partial payment or denial under 28 Texas Administrative Code (TAC) Section 134.110(f). Complete this section or use your own form and send a copy to the injured employee and the injured employee's representative, if any.

12. Response Requested amount is: ☐ Approved ☐ Denied ☐ Partially Denied	**13. Reason for denial:**	
14. Adjuster name:	**15. License number:**	**16. Date:**



FAQ

Request to get reimbursed for travel costs (DWC Form-048)

What costs can I get reimbursed for?
If you have a work-related injury, you can get reimbursed for travel costs for some medical treatments or exams more than 30 miles one way if:

- Medical treatment is not reasonably available within 30 miles of where you live; or
- Required medical exams, designated doctor exams, and post-designated doctor, treating doctor, or referral doctor exams are more than 30 miles one way.

If you have more costs to submit, you may attach more pages. Include the information in boxes 8 and 9.

Mileage: If you travel from your home or workplace to the health care provider's office, you can get reimbursed for mileage using the shortest reasonable route. Some things to know:

- Talk to your adjuster if you have questions about getting reimbursed for mileage because of medical treatment or exams that are not reasonably available within 30 miles of where you live.
- If you left from a place other than your home or workplace, mileage will be based on the distance from the health care provider's office to your home, workplace, or actual point of departure, whichever is closest.
- The amount reimbursed will be based on the travel rate for state employees. To get those rates, go to fmx.cpa.texas.gov/fmx/travel/textravel/rates/current.php or call us at 800-252-7031.

Hotel and meals: If your travel reasonably includes an overnight stay, you can get reimbursed for the cost of a hotel or other lodging and meals related to your trip. Some things to know:

- Talk to your adjuster if you have questions about whether it's reasonable for your travel to include an overnight stay.
- You must send a copy of receipts for an overnight stay and your meals with this form.
- The amount reimbursed cannot be more than the rates for state employees. To get those rates, go to fmx.cpa.texas.gov/fmx/travel/textravel/rates/current.php or call us at 800-252-7031.

What happens next?
Within 45 days of getting your form, the insurance carrier must reimburse your request for travel costs or deny your request by completing this form or using its own form explaining why it won't pay for the travel.

You can ask for a benefit review conference if the insurance carrier won't reimburse all or part of your travel costs. At the conference, someone from DWC will listen to you and the insurance carrier and try to help you reach an agreement. An injured employee who is not represented by an attorney may also get help by contacting the Office of Injured Employee Counsel at 866-393-6432.

More information: See 28 TAC Section 134.110 about reimbursement of travel expenses, Labor Code Section 408.004(c)(2) and 28 TAC Section 126.6(l) about required medical exams, and Labor Code Section 408.0041(h)(2) and 28 TAC Section 126.17(c) about post-designated doctor treating or referral doctor exams.

Note: With few exceptions, on your request, you are entitled to:

- be informed about the information DWC collects about you;
- receive and review the information (Government Code Sections 552.021 and 552.023); and
- have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact DWCLegalServices@tdi.texas.gov or go to the Corrections Procedure section at www.tdi.texas.gov.

Office of Injured Employee Counsel

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.**