WORKER'S COMPENSATION CLAIM PROCESS

1. Employee Reports Injury to their Supervisor or to the County Administrator Office;

2. Injury Report Packet available in the Department, on the Common Drive in the County Administrator/Forms Folder, or by contacting the County Administrator's Office.

   Packet includes:

   a. Employee Report (Employee to Complete)
   b. Supervisor Report (Supervisor to Complete)
   c. Release for Health Care records (Employee to Complete)
   d. Work Recommendation Form for Physician (Employee Give to Physician)
   e. Pharmacy Prescription Form (Employee Take to Pharmacy)

3. Accident Report Forms (Employee and Supervisor Reports) turned in to County Administrator's Office (within 24-hours whenever possible).

4. If employee seeks medical attention, Release for Health Care Records turned in to County Administrator's Office.

5. If employee seeks medical attention, Work Recommendation Form from Physician provided to County Administrator's Office following any medical appointments.

6. Department Head to work with County Administrator to determine opportunities for duties within work restrictions.

7. Department Head to provide County Administrator's Office with a copy of the Employee's work schedule and a detailed work time record for the duration of the worker's compensation claim.

TO BE COMPLETED BY INJURED **EMPLOYEE;**

Employee Name (First Middle, Last)		Social Security Number	Sex ☐M ☐F	Employee Home Telephone No,
Employee Street Address	City	State	Zip Code	Occupation
Today's Date	Date of Hire	What Department do you work in?		

DATE INJURY OCCURRED: TIME OF INJURY: DATE EMPLOYER NOTIFIED:

Indicate the name of the individual to which you reported the injury:

IN YOUR OWN WORDS, EXPLAIN IN DETAIL WHAT YOU WERE DOING IMMEDIATELY BEFORE THE ACCIDENT AND HOW THE ACCIDENT HAPPENED. Include as much detail as possible including where the accident/injury happened, what part of the body was injured and how the injury occurred:

Exact Location that Injury Occurred :

List Any Witnesses To The Incident:

Did You Or Will You Seek Medical Treatment? ☐ YES ☐ NO
Did you leave work due to the injury? ☐ YES ☐ NO
Please check the appropriate box:
Did Not Lose Any Work Time: ☐ YES ☐ NO
Currently Off Work: ☐ YES ☐ NO

If Yes, What time and date did you leave work:

Physician's Name:
Physicians Address:
Physician's Phone:

I HEREBY CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE DATE

NOTICE TO EMPLOYEE:

- **Complete and submit this report to your supervisor within 24-hours whenever possible.**

IF YOU SEEK MEDICAL ATTENTION:

- Get a **written** report from your physician following **each** medical visit. Use the attached "*Work Recommendations*" form for this purpose.
- If a prescription is needed, present the attached "*myMatrixx*" form at the pharmacy.
- Complete the "*Voluntary and Informed Consent for Disclosure of Health Care Information*" form and return it to the County Administrator's Office. This will allow the release of your medical records and assist in speeding up the worker's compensation claim.

ACCIDENT/ILLNESS/INCIDENT INVESTIGATION REPORT

Part 1. Supervisor completes: To be filled out by supervisor. Employee required to report accidents/incidents to their supervisor immediately at the time it occurs.

NAME OF INJURED PERSON	CHECK ONE ☐ EMPLOYEE ☐ VISITOR ☐ VOLUNTEER
DATE OF REPORT	NAME/POSITION OF PERSON PREPARING REPORT
SUPERVISOR TELEPHONE NO.	INTERNAL DEPT. (EX. HEALTH CARE, HR/COA
DATE OF INJURY: TIME:	☐ AM ☐ PM LEFT WORK ☐ YES ☐ NO
ADDRESS OF ACCIDENT	
WHAT WAS EMPLOYEE DOING WHEN INJURED? Be specific. If using equipment, please name them.	
HOW DID THE ACCIDENT OCCUR?	
HOW LONG HAS THE EMPLOYEE BEEN DOING JOB? DAYS MONTHS YEARS	
WHAT SAFETY EQUIPMENT IS REQUIRED ON THE JOF FOR THE WORK BEING PERFORMED?	
WAS THE EMPLOYEE USING ALL REQUIRED SAFETY EQUIPMENT? ☐ YES ☐ NO	
IF NO, WHICH SPECIFIC PERSONAL PROTECTIVE EQUIPMENT WAS NOT USED & WHY?	
DOES AN UNSAFE CONDITION EXIST THAT CONTRIBUTED TO THE CAUSE? ☐ YES ☐ NO	
IF YES, WHAT IS THE CONDITION?	
HOW COULD THE ACCIDENT BEEN PREVENTED? BE SPECIFIC.	
CORRECTIVE ACTION TAKEN BY SUPERVISOR: ☐ YES ☐ NO DATE	
Reinstruction of person(s) involved	
Equipment repair/replacement	
Improved personal protection equipment	
Reduced congestion	
Improved design/construction	
Discipline of person(s) involved	
Other	
IN DETAIL, EXPLAIN ACTION TAKEN TO PREVENT RECURRENCE:	

Voluntary and Informed Consent for Disclosure of Health Care Information

The provision of your social security number is mandatory under Wisconsin Statutes and will be used to identify the claimant. Failure to provide it may result in penalties or delayed payment of benefits. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://dwd.wisconsin.gov/wc/
e-mail: DWDDWC@dwd.wisconsin.gov

By law, all health care providers must provide to any employee, employer, worker's compensation insurer or their representative any information reasonably related to any alleged work injury. However, determining the relationship of prior medical records to a work injury can be difficult and time-consuming. Therefore, to assist in the timely investigation of your claim, this document authorizes the health care provider to release medical information without attempting to determine the extent of its relationship to your alleged work injury.

You are not required to sign this document. You may refuse to sign this document without jeopardizing your right to collect worker's compensation benefits. However, by assisting in the investigation of your claim, you are likely to receive benefits quicker than if you refuse to authorize the release of medical information.

Health Care Provider Name **All Providers**		Street Address	
P. O. Box	City	State	Zip Code
Patient (Employee) Name	Employer Name		
Patient Social Security Number	Patient Birth Date	WC Claim No.	

The patient named above hereby authorizes the health care provider named above to disclose all records checked below in its possession relating to the patient's health, treatment and evaluation to:

Name and Address of Party Authorized to Receive Protected Information
West Bend Mutual Insurance Company, 1900 South 18th Avenue, West Bend, WI 53095

or its designated representatives, and to furnish to them a legible, certified duplicate of all records, writings, reports, test results and x-rays in its possession containing such information. This authorization includes *all* records, reports, correspondence, or other materials in the possession of the health care provider authorized, even if those materials were not generated by the health care provider, and the redisclosure of such materials is hereby authorized. This release is for use in the investigation, preparation, evaluation, and/or hearing of the worker's compensation claim described above.

CHECK ONE:

☐ **A. Physical Only.** Release all records, correspondence, and any other information from whatever source regarding the patient's physical health, treatment and evaluation including, but not limited to, any made or provided by any physician, nurse, chiropractor, osteopath, dentist, physical therapist, hospital, or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited to Wis. Stat. §§ 146.81 and 146.82, and 45 C.F.R. § 164.508.

☐ **B. Physical and Other.** Release all records, correspondence, and any other information from whatever source regarding the patient's physical and mental health, drug and alcohol abuse, HIV and AIDS tests, treatment, and evaluation including, but not limited to, any made or provided by any physician, psychiatrist, psychologist, nurse, chiropractor, osteopath, dentist, physical therapist, hospital or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited to Wis. Stat. §§ 51.30, 146.025, 146.81 and 146.82, 42 C.F.R., Chap. 1, subpart C, § 2.31 and 45 C.F.R. § 164.508.

Patient Signature (or Person Authorized to Sign for Patient) — for Option B

Patient Signature (or Person Authorized to Sign for Patient)	Date

WKC-9488 (R. 03/2009)

ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD

Claim No.
VJV 1491016

Patient's Name (First) (Middle Initial) (Last)	Date of Injury/Illness

TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK

Diagnosis/Condition (Brief Explanation)

I saw and treated this patient on _____ (date) and based on the above description of the patient's current medical problem:

1. ☐ **Recommend his/her return to work with no limitations on** _____ (date)

2. ☐ **He/She may return to work on** _____ (date) **capable of performing the degree of work checked below with the following limitations:**

- ☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.
- ☐ **Light Work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.
- ☐ **Light Medium Work.** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.
- ☐ **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.
- ☐ **Medium Heavy Work.** Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.
- ☐ **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

1. In an 8 hour work day patient may:
   a. Stand/Walk
      ☐None ☐1-4 hours ☐4-6 hours ☐6-8 hours
   b. Sit
      ☐1-3 hours ☐3-5 hours ☐5-8 hours
   c. Drive
      ☐1-3 hours ☐3-5 hours ☐5-8 hours
2. Patient may use hand(s) for repetitive:
   ☐Single Grasping
   ☐Pushing & Pulling
   ☐Fine Manipulation
3. Patient may use foot/feet for repetitive movement as in operating foot controls:
   ☐Yes ☐No
4. Patient is able to:

	Frequently	Occasionally	Not At All
a. Bend	☐	☐	☐
b. Squat	☐	☐	☐
c. Climb	☐	☐	☐
d. Twist	☐	☐	☐
e. Reach	☐	☐	☐

Other Instructions and/or Limitations Including Prescribed Medications:

These restrictions are in effect until _____ (date) or until patient is re-evaluated on _____ (date)

3. ☐ **He/She is totally incapacitated at this time. Patient will be re-evaluated on** _____ (date)

Physician's Signature	Date

West Bend Mutual Insurance Company
1900 South 18th Avenue
West Bend, Wisconsin 53095

WEST BEND
A MUTUAL INSURANCE COMPANY™

myMatrixx™
good medicine for business

WEST BEND MUTUAL INSURANCE COMPANY
WORKERS' COMPENSATION PRESCRIPTION INFORMATION

Employer:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

Employee Name:	
Group #:	10602270
Member ID (SSN):	
Date of Injury:	
Claim Number:	
Processor:	myMatrixx
Bin #:	014211
Day supply is limited to 3 days for a new injury	
myMatrixx Help Desk: (877) 804-4900	

Employer Signature:	Phone:	Date:

Injured Worker:

West Bend 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 60,000 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 MEDICATIONS(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. Document only valid if signed and dated by employer above.

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 other will require prior approval.

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