IN CASE OF WORKPLACE INJURY

ACCION a seguir en caso de un accidente en el trabajo

AVAILABLE 24 HOURS A DAY

1-877-545-9148

1. **Injured worker notifies supervisor.**
   Empleado lesionado notifica a su supervisor.

2. **Supervisor/Injured worker immediately calls injury contact center.**
   Supervisor / Empleado lesionado llama de imediato al centro de contacto para lesiones.

3. **Company Nurse gathers information over the phone and helps injured worker access appropriate medical treatment.**
   Company Nurse obtiene información por teléfono y asiste al empleado lesionado en adquirir el tratamiento médico adecuado.

NOTICE TO EMPLOYER/SUPERVISOR: Please post copies of this poster in multiple locations within your worksite. If the injury is non-life-threatening, please call Company Nurse prior to seeking treatment. Minor injuries should be reported prior to leaving the job site, when possible.

EMPLOYEE REPORT OF INJURY

FAX IMMEDIATELY OR WITHIN 24 HOURS TO 217.403.4901

Employee Name:	Place of Employment:		Date Hired
Home Address Street: ____________ City: ____________ State: ________ Zip: ________ Home Phone #: ( )	Date of Incident:	Reported To:	Date Reported:
	Time of Incident: AM/PM	Shift at time of injury 1st 2nd 3rd	Full Time: ☐ Part Time: ☐ Hours per week: _____
	Date of Birth:	Marital Status: M S W D	# Dependents under 18:
Social Security Number:	Please describe how you were injured?		
Using the above drawing, circle any and all areas hurt as a result of the incident	Which part(s) of your body were hurt? Please include specific detail. (example: left or right; upper or lower)		
	Previous injury(s) to same body part? Describe (include date of injury)		
	Who was present when incident occurred?		

Do you have any secondary form of employment? YES ☐ NO ☐ — If yes, please describe (include name/address of employer):

If yes, is your supervisor here aware of your 2nd job? YES ☐ NO ☐ — If yes, supervisor's name:

Are you going to seek medical treatment? ☐ Yes ☐No
If so, name and address of medical provider?

I agree that the above report is true and accurate

Signature: ______________________________ **Today's Date:** ____________

- ALL REPORTS SHOULD BE GIVEN TO YOUR SUPERVISOR IMMEDIATELY AFTER ANY INCIDENT -

AUTHORIZATION FOR MEDICAL INFORMATION

I hereby authorize any physician, hospital, pharmacy, employer or other person or organization possessing non-medical and medical information to permit NHRMA Mutual or it's representatives to view, copy, be given details of all such non-medical and medical information including drug, alcohol or psychiatric treatment and/or testing. I also agree that any and all of my health care providers may discuss the details of my medical information with the representatives of NHRMA Mutual. This authorization shall remain valid unless revoked in writing with notice to NHRMA Mutual. Upon representation of this authorization or photocopy of it, I give permission for personal review or photocopying of the information by any representative of NHRMA Mutual.

THIS IS NOT A RELEASE OF CLAIM FOR DAMAGES

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Patients Signature **Date**

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION AND RELEASE TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION AND RECORDS

I , hereby authorize you, your employees and agents, to use and disclose my protected health information and records to NHRMA Mutual, their employees, agents, representatives, insurers and attorneys. I understand that the purpose of the disclosure is to provide information and records in connection with a workers' compensation claim I am pursuing. I therefore authorize the release of all records in your possession, including all patient information/registration forms, office notes, radiology and other diagnostic test reports and films, laboratory test reports, electrodiagnostic test reports and tracings, physical and occupational therapy notes and records, functional capacity evaluations, off work and return to work slips, narrative reports, consultation reports, insurance forms and records, records of any medical or disability benefits paid by any group plan, records received from other physicians and health care providers, alcohol and/or chemical dependency or treatment records, AIDs or HIV information, testing or records, genetic testing, statement of charges, payments, write-offs and adjustments, psychological, psychiatric and psychotherapy reports, notes and test results, telephone messages, correspondence, and hospital records including face sheets, emergency room records, triage reports, EMS records, history and physical, discharge summary, operative reports, pathology reports, nurses' notes and physicians' notes.

I understand that the medical provider(s) may not condition health care treatment, payment, or eligibility for benefits upon my execution of this Authorization.

I also specifically authorize any treating physician or other medical care provider, their employees, agents, and representatives, to communicate orally or in writing with my employer, its insurer, claims administrator, case managers, or attorneys as to my care and treatment, and as to any other issue related to my workers' compensation claim including medical history, prior injuries, diagnosis, prognosis, causal connection, ability to work, and the nature and extent of my disability. I also authorize any treating physician or other medical provider to review and comment on any materials received from my employer, its insurer, claims administrator, case managers, or attorneys which relate to said claim.

I understand that I may revoke this Authorization, in writing, at any time. However, such revocation will be ineffective for uses or disclosures that have already been made in reliance upon this Authorization. Unless revoked by me sooner, this Authorization shall be effective for the next three (3) years or until the final resolution of my workers' compensation claim, whichever occurs later.

I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected under the Health Insurance Portability and Accountability Act of 1996 **(HIPAA).**

A photocopy of this Authorization shall be as valid as the original I understand that I may, at any time, inspect or obtain a copy of this Authorization.

I ACCEPT THESE TERMS AND AUTHORIZE THE ABOVE USE AND DISCLOSURE:

____

Signature of Patient or Legally Authorized Representative Date

____

If not Patient, then relationship of Legally Authorized Representative Date
To Patient

Witness Statement Form

1) Name of witness (first & last name):		
2) Primary contact number:		
3) Secondary contact number:		
4) Home address of witness:		
City:	State:	Zip:
5) Witness Employer:		
6) Were you involved in the accident (i.e. driver, passenger, etc.):		
7) Did you witness the accident:		
8) Location of witness (be specific):		
9) Name of individual involved in accident:		
10) Date of accident:		
11) Time of accident:		
12) Location of accident (Address, name of building, mile marker, etc.):		
13) Area of accident (bathroom, parking lot, etc.):		
14) Describe fully how the accident occurred (Including the events that occurred immediately before):		
15) Describe visual bodily injuries sustained (be specific about body part(s) affected):		
16) Why do you think the accident happened:		
17) Name(s) of other witnesses:		
18) Signature of witness:		
19) Date:		

Supervisor Accident Investigation

A. Injured Employee Data					
Employee Name:			Position:		Personnel Number:
Work Location					
Date of Accident	Time of Accident ☐ a.m. ☐ p.m.		Claim Number (if known)		
Home Telephone	Work Telephone		Other/Cell Number		
Supervisor				Supervisor Telephone Number	
B. Accident Description					
1. Where did the accident happen and who was involved? Provide a full description of the surroundings of the location and the individuals involved.					
2. What was happening at the time of the accident and why was it taking place?					
3. What exactly caused the injury and how did it happen? What were the mechanics, equipment or tools involved?					
4. Describe the injury or injuries incurred. What body part and what kind of injury? (Indicate if no injury occurred.)					
Signature of Supervisor or Accident Investigator			Date		Time ☐ a.m. ☐ p.m.

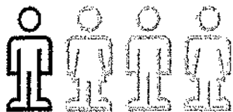
CVS caremark

CORVEL

Opioid Safety: What you need to know

Opioid misuse and abuse is a growing concern in our country. You may be taking (or have taken) a prescribed opioid such as oxycodone or hydrocodone to help relieve pain. Drugs like these are generally safe when taken exactly as directed for a limited period, but can become harmful—even fatal—if misused. It's important to be informed about the risks and benefits of opioid medication use should your doctor prescribe them to manage your pain.

Prescription opioids can help to manage short-term pain that may occur after a surgery or recent injury. But they may not work as well to manage chronic pain long-term. In addition, you're more likely to overdose or become addicted when using opioids for a long time. An overdose can cause serious health problems or even death. There may be other treatments available with less serious risks. Work with your doctor to find the safest, most appropriate ways to manage your condition.



As many as

1 in 4

taking prescription opioids struggle with addiction when opioids are used long-term.[1]

Safety tips to consider when you are prescribed opioid medication:

- Always take your medication exactly as instructed by your doctor.
- Never share your opioids with others.
- Avoid alcohol and certain medications that may interact with your opioids.
- Review your medication list with your doctor or pharmacist.
- Follow up regularly with your doctor.
- Store opioids in a secure place, ideally a locked location.
- Dispose of unused opioids properly. Check with your pharmacy regarding safe disposal methods.

Please note: Some insurance plans may allow opioid fills with a limited day supply. Please call **CorVel Pharmacy Solutions at 800-563-8438** with any questions regarding your plan.

1. Prescription opioid overdose data. U.S. Centers for Disease Control and Prevention. Last updated August 1, 2017 https://www.cdc.gov/drugoverdose/data/overdose.html. Accessed January 10, 2018.

This information is not a substitute for medical advice or treatment. Talk to your doctor or health care provider about this information and any health-related questions you have. CVS Caremark assumes no liability whatsoever for the information provided or for any diagnosis or treatment made as a result of this information.

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Injured Worker's
First Fill Prescription Form

Employee Name: ______________________________

Date of Injury:____________________ SSN: ____________________

Injured Worker Instructions

On your first Pharmacy visit, please give this notice to any pharmacy listed on this insert. This will expedite the processing of your approved workers' compensation prescriptions, based on the parameters established by **NHRMA Mutual.** With the CorVel pharmacy program, you do not need to complete any paperwork or claim forms. Simply present this CorVel First Fill Prescription Form to the pharmacy. You should not incur any costs or co-pays at the pharmacy and you will be allowed up to a 14-day supply of most medications.

Notice to Injured Worker and Pharmacy

This temporary First Fill card is only valid if used within 30 days of the reported date of injury. Temporary eligibility through this program allows for a one-time fill of prescription medications. For assistance with processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.**

Pharmacy Instructions

For assistance processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.** Please use the BIN, PCN, and RxGroup number below to process an online/electronic claim to CorVel:

CORVEL CVS CAREMARK

BIN: 004336
PCN: ADV
RxGroup: RXFFWC9254283
Member ID: See below to generate ID

To generate member ID: The Injured Worker's 9 digit social security number plus 8 digit date of injury will be used as their 17 digit **member identification number** when processing their First Fill Prescription:
XXXXXXXXXMMDDYYYY

Below is a sample listing of some of the over 62,000 Participating Pharmacies in the CorVel Network. Please call **(800)563-8438** for a participating pharmacy near you.

CostCo Pharmacy	H.E.B. Pharmacies	Meijer Pharmacy	Smith's Food & Drug Centers
CVS	Hy-Vee Pharmacy	Publix Pharmacy	Target Pharmacy
Duane Reade	Ingles Pharmacy	Raley's Drug Center	Von's Pharmacy
Drug Mart	Kroger Pharmacy	Rite Aid Pharmacy	Wal-Mart Pharmacy
Fred's Pharmacy	Longs Drug Store	Safeway Pharmacy	Walgreens Pharmacy
Giant Eagle Pharmacy	Marc's Pharmacy	Sav-On Drug Store	Wegman Pharmacy