KILLEEN ISD WORKERS' COMPENSATION PACKET
GENERAL INSTRUCTIONS:

For life threating emergencies, please direct injured employee to the nearest Emergency Room. Please ensure the injured employee leaves with a Verification of Employment for a Reported Workers' Compensation Injury or Illness and an Optum Medical First Fill Card.

NOTE: A First Report of Injury must be filed once and employee reports or the campus is made aware of any on the job injury, illness or incident. Personal insurance does not cover medical treatment for compensable workers' compensation injury.

1. Upon notification of an employee's work related injury or illness, an Employers First Report of Injury (FROI) must be completed via the TASB site, www.tasbrmf.org. Completed paperwork and any witness statements should be emailed to workerscomphr@killeenisd.org no later than the next business day.
   Print a copy of the First Report of Injury for your records.
2. Forms below will need to be completed and signed by the employee and emailed or faxed to: workerscomphr@killeenisd.org or 254-336-0091.
   - Employee Acknowledgement of Alliance
   - Leave Election Form
   - Employee Statement
   - Witness Statement (if applicable)
3. If employee feels that they need to seek medical treatment, they should be provided with the following:
   - Verification of Employment for Reported Workers' Compensation Claim Form
   - Optum First Fill Card
4. Make sure to notify the **Risk Management Department**:
   - If the employee misses any time
   - Returns to work

To search for a primary care alliance physician in the local area go the Political Subdivision Workers' Comp Alliance website (www.pswca.org) and go to the Find a Doctor link.

All signed paperwork must be emailed or faxed no later than the next business day workerscomphr@killeenisd.org or 254-336-0091

All questions or concerns should be directed to Risk Management at 254-336-0068 or 254-336-0115.

District's Workers' Compensation Insurance Carrier

Texas Association of School Boards (TASB)
PO Box 2010
Austin, TX 78768-2010
1-800-482-7276

CLAIM # _____

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ○ M ○

3. Employee ID Number

4. Phone Number

5. Date of Birth (m-d-yy)

6. Does the Employee Speak English? If No, Specify Language

YES ☐ NO ☐

7. Race

Black ☐ Asian ☐ White ☐

8. Ethnicity

Native American ☐ Other ☐ Hispanic ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status

Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children

12. Spouse's Name

13. Primary Doctor's Name

14. Doctor's Mailing Address

City State Zip Code

15. Date of Injury (m-d-yy)

16. Time of Injury : am ☐ pm ☐

17. Date Lost Time Began (m-d-yy)

18. Type of Injury*

19. Part of Body Injured or Exposed*

20. How and Why Injury/Illness Occurred*

21. Was employee doing his regular job? YES ○ NO ○

22. Worksite Location of Injury (stairs, dock, etc.)*

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site

Street, P.O. Box, or School Name County

City State Zip Code

24. Cause of Injury(fall, tool, machine, etc.)*

25. List Witnesses

26. Return to work date/or expected (m-d-y)

27. Did employee die? YES ☐ NO ☐

28. Supervisor's Name

29. Date Reported (m-d-y)

30. Name and Title of Person Completing Form

31. Name of Business

Killeen Independent School District

32. Business Mailing Address and Telephone Number

Street or P.O. Box: P.O. Box 967

Telephone: (254) 336-0068

City: Killeen State: TX Zip Code: 76540

33. Business Location (If different from mailing address)

Number and Street: 2301 Atkinson Avenue

City: Killeen State: TX Zip Code: 76543

34. Federal Tax Identification Number: 74-6001505

35. Primary North American Industry Classification System Code:(6 digit) 61111

36. Specific NAICS Code (6 digit)

37. Texas Comptroller Taxpayer No.: 99-99021-0

38. Workers' Compensation Insurance Company

Texas Association of Schools Boards (TASB)

39. Policy Number

WC-1200

40. Did you request accident prevention services in past 12 months?

YES, ○ NO ○ If yes, did you receive them? YES ○ NO ○

41. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)

X _____ Date _____

DWC FORM-1 (Rev. 10/05)

DIVISION OF WORKERS' COMPENSATION

KILLEEN INDEPENDENT SCHOOL DISTRICT
EMPLOYEE ACKNOWLEGEMENT OF THE ALLIANCE DIRECT CONTRACTING PROGRAM

I have received information that tells me how to get health care under my employer's workers' compensation coverage. If I am hurt on the job and live in a service area described in this information, I understand that:

1. I must choose a treating doctor from the Alliance list of doctors designated as treating doctors.

2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go to any licensed medical professional within the United States.

3. Even though my treating doctor should refer me to a specialist of providers contracted with the Alliance, I understand that I need to verify that the referral doctor is a member of the Alliance provider panel.

4. The Texas Association of School Boards Risk Management Fund will pay the treating doctor and other Alliance providers for all health care related to my compensable injury.

5. I understand that my medical and/or income benefits may be disputed if I receive health care from a provider other than an Alliance provider without prior approval from the Fund.

6. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.

7. If I want to change doctors after my first choice, I can do so within the first 60 days of starting treatment, and I can only choose from the Alliance list of providers. A third choice requires approval from my adjuster.

Signature _____ Date _____

Printed Name _____

I live at _____
Street Address City State Zip Code

Name of Employer: __KILLEEN INDEPENDENT SCHOOL DISTRICT_____

Name of Direct Contracting Program: Political Subdivision Workers' Compensation Alliance (the Alliance)

Direct contracting service areas are subject to change. To locate a treating doctor within your area, visit the PSWCA web site at www.pswca.org or call your adjuster at 800.482.7276.

KILLEEN INDEPENDENT SCHOOL DISTRICT
CLINIC EMPLOYEE INJURY EVALUATION

Employee's Name _____ Date of Birth _____

Campus/Department _____ Job Title_____

Date of Injury _____ Time _____ ☐ a.m. ☐ p.m.

Location of Accident/Injury: ☐ classroom room #_____

☐ hallway ☐ office ☐ gym ☐ playground ☐ kitchen

☐ other (describe)_____

Employee's Description of Incident

_____

_____

_____

_____

Complaint/Observation

_____

_____

_____

_____

Employee Reported to Clinic for Evaluation

Date_____ Time_____ Nurse/Aide _____

Clinic Action

_____

_____

_____

_____

Nurse/Aide Signature_____ Date _____

**Please provide the injured employee with a completed copy of this form and direct them to the Reasonable Report for their assigned campus or department to complete a workers' compensation packet.*

KILLEEN INDEPENDENT SCHOOL DISTRICT
INJURED EMPLOYEE'S STATEMENT

Name_____ Employee ID#_____

Campus/Department _____ Job Title_____

Location of Accident/Injury: ☐ classroom room #_____

☐ hallway ☐ office ☐ gym ☐ playground ☐ kitchen

☐ other (describe)_____

Date of Injury: _____ Time: _____ a.m. ☐ p.m. ☐

Description of Incident (*where you were, what you were doing and how you were injured*)

_____

_____

_____

_____

_____

Body Part(s) Affected ☐ right ☐ left

_____,_____,_____,_____,_____

_____,_____,_____,_____,_____

Employee's Signature_____ Date _____

KILLEEN INDEPENDENT SCHOOL DISTRICT
WITNESS STATEMENT

Name of Injured Employee_____ Job Title_____

Name of Witness_____ Job Title_____

Campus/Department _____

Location of Accident/Injury: ☐ classroom room #_____

☐ hallway ☐ office ☐ gym ☐ playground ☐ kitchen

☐ other (describe)_____

Date of Injury: _____ Time: _____ a.m. ☐ p.m. ☐

Did you witness the accident? ☐ Yes ☐ No

Description of Accident (*where you were, what you were doing and what you saw*)

Body Part(s) Affected ☐ right ☐ left

_____,_____,_____,_____,_____

_____,_____,_____,_____,_____

Witness' Signature_____ Date _____

KILLEEN INDEPENDENT SCHOOL DISTRICT
LEAVE ELECTION FORM

Name _____ **Employee number** _____

Position _____ **Department/Campus** _____

This employee is absent from duty because of a job-related illness or injury beginning on _____
(date of first absence attributable to illness or injury).

If eligible, workers' compensation insurance may begin paying a percentage of the employee's current wages on the eighth day of absence from duty if an extended absence is required.

_____ _____

District authorized signature Date

EMPLOYEE CHOICE: (Please chose one only)

If I am absent from duty because of a job-related illness or injury, I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days and that I am responsible for reporting my absences to mu supervisor. I also understand that the district will continue to pay its contribution toward the cost of my group health insurance coverage (if applicable) as long as I am on **paid** leave and/or family and medical leave **(FMLA)**. I further understand that I will be responsible for paying all health insurance premiums if I am on **unpaid** leave that is not FMLA leave. I choose the following option:

☐ I choose to use only _____ days of available paid leave at this time. ***(you must indicate # of days)***

☐ I choose to use all available paid leave. During the first seven calendar days, my leave will be used in full-day increments. I understand that once I begin to receive workers' compensation weekly income benefits, my leave will be used in partial-day increments to supplement workers' compensation income benefits.

☐ I choose **not** to use any available paid leave at this time. I understand that I will not receive any regular salary payments from Killeen ISD while receiving weekly income benefits under workers' compensation. No available paid leave will be deducted from my leave balance. I further understand that by selecting this option, I will receive only workers' compensation income benefits for any absences resulting from my work-related illness or injury, unless and until I communicate to the district a change in my decision.

**** If you are out more than FIVE (5) consecutive days, it is *your responsibility* to contact the Leaves Department at leaveshr@killeenisd.org or (254) 336-0045.**

_____ _____

Employee signature Date

For Claims Reporting Purposes Only:	
For all employees: Amount of leave paid to employee: $ ____.__ Daily rate: $ _____ Period of payment: from___/___/___ through___/___/___ for ____ days **or** ____ weeks	*For hourly employees only:* Hourly rate: $____.___ Number of hours paid: _____

KILLEEN INDEPENDENT SCHOOL DISTRICT
VERIFICATION OF EMPLOYMENT FOR A REPORTED WORKERS' COMPENSATION INJURY OR ILLNESS

Employee Name_____ Date of Injury_____

Date of Birth_____ Social Security_____

Facility I plan to seek medical treatment at _____

Reported Work Related Injury or Illness_____

Killeen ISD's workers' compensation coverage provider is the Texas Association of School Boards Risk Management Fund, which is a member of the Political Subdivision Workers' Compensation Alliance (the Alliance). For emergencies, an injured employee may go to the nearest emergency room. Otherwise, all other treatment must be from an Alliance Provider listed at www.pswca.org.

Please submit all claim and medical billing information to:

TASB Risk Management Fund
PO Box 2010
Austin, TX 78768-2010
Phone: (800) 482-7276
Fax: (800) 580-6720
Pre-Authorization-Phone: (800) 482-7276 ext. 6654 Fax: (888) 777-8272

Killeen ISD has implemented a modified duty, Return to Work Program, which is designed to return an injured employee to the workplace as soon as medically possible. If this employee is unable to return to his/her original job, we will make every attempt to return this employee to a temporary modified duty assignment. We will ensure the temporary position meets with all medical restrictions that you prescribe.

Issuing Signature Shelly Frishman Title Secretary IV Risk Management

Phone Number 254-336-0068 Date_____

Providers please submit Work Status Reports and all Job Description Inquiries to:

Killeen ISD Office of Risk Management
Email: workerscomphr@killeenisd.org
Fax: (254) 336-0091

Facility Name	Address	Hours	Phone	Notes
Walk-In Facilities				
Elms Creek Family & Urgent Care	3816 S. Clear Creek Rd. Suite E, Killeen	Mon-Thurs 9am-5pm Fri 9am-12pm	254-554-8773	** New patients must arrive before 4:30 pm Mon-Thurs and before 11:30 am on Fridays
Freedom Urgent Care-Clear Creek Rd.	2810 Clear Creek Rd. , Killeen	Mon-Fri 8am-9pm Sat & Sun 9am-6pm	254-312-4900	** Follow up visits will be at the Harker Heights location
Freedom Urgent Care- Killeen	3202 S. WS Young Dr., Killeen	Mon-Fri 8am-9pm Sat & Sun 9am-6pm	254-781-5446	** Follow up visits will be at the Harker Heights location
Freedom Urgent Care-Harker Heights	300 W. Central Tx Expy Suite 115, Harker Heights	Mon-Fri 8am-9pm Sat & Sun 9am-6pm	254-833-8456	
Integrity Urgent Care- Killeen	2520 Trimmier Rd. Suite 100, Killeen	8am-8pm 7 days a week	254-390-9110	
Integrity Urgent Care-Killeen West	3100 W. Stan Schlueter Loop, Killeen	8am-9=8pm 7 days a week	254-200-4700	
Integrity Urgent Care-Copperas Cove	3010 E. Bus. 190 Suite 254, Copperas Cove	8am-9=8pm 7 days a week	254-577-5642	
Nova Medical Centers ****NEW****	3150 S. 31st St. Temple	Mon-Fri 8:30 am-6:00 pm	254-342-3836	
Premier Urgent Care Plus	7010 W. Adams Ave. Suite 200, Temple	7am-9pm 7 days a week	254-228-1200	** This facility provides a one-time initial visit only. Continued treatment will be with another provider of your choosing within the alliance
AFC Urgent Care	3614 SW HK Dodgen Loop Suite F, Temple	9am-5pm Mon-Fri Sat 9am-3pm	254-295-0117	Hours noted are for workers' compensation patients. *Requires a treatment authorization form that Risk Management must fax to them ahead of the visit
Baylor Scott & White Convenient Care-Belton	309 Lake Rd, Belton	8am -7:30 pm 7 days a week	254-933-5600	** This facility provides a one-time initial visit only. Continued treatment will be with Baylor Scott & White Occupational Medicine or another provider of your choosing within the alliance
Clinics Requiring an Appointment				
Baylor Scott & White Occupational Medicine	2401 S. 31st Street, Temple	Mon-Fri 8am-5pm	254-724-5901	
Advent Health FMC	2401 Walker Place Blvd, Copperas Cove	Mon-Fri 8am-5pm Sat 9am-12pm	254-547-7777	
Advent Health FMC Lampasas	187 PR 4060, Lampasas	Mon-Fri 8am-5pm Sat 9am-12pm	512-556-3621	

** The injured employee must take the Verification of Employment for a Reported Workers' Compensation Injury or Illness with them to the treating facility along with a photo ID.

OPTUM®

TASB RISK MANAGEMENT FUND

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...

TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for TASB Risk Management Fund. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

TASB RISK MANAGEMENT FUND

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

TASB Risk Management Fund	Killeen ISD
CARRIER/TPA	EMPLOYER
INJURED WORKER NAME	
Please provide directly to Pharmacist	
SOCIAL SECURITY NUMBER	DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.
Tmesys is the designated PBM for this patient. This card is not valid for compound medications.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	TASBFF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-167

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para TASB Risk Management Fund. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM®

TASB RISK MANAGEMENT FUND

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

TASB Risk Management Fund
PORTADORA EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient. This card is not valid for compound medications.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	TASBFF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-167