Notice to Department Head or Elected Official

The employer (Bee County) is required to file an Employer's First Report of Injury or Illness [DWC FORM-001 Rev. 10/05] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

The Employer's First Report of Injury or Illness provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. Details of the claimant's employment and circumstances surrounding the injury or illness are also requested.

It is very important that you send the Accident/Injury Report to the HR Department Room 305 ASAP, so that we can submit the DWC-001. The HR Department will file the report. We need the Accident/Injury Report to do so, and to stay within the timeframe required by the Texas Association of Counties (TAC), to be in compliance and eliminate the risk of Workers' Compensation Benefits from being denied.

- You will also need to fill out the top part of the **Workers' Compensation Authorization for Medical Attention** form.

  Sign your part (Dept. Head), and then give to the Employee to give to his/her physician.

Thank you for your cooperation in this matter.

Human Resources Department-Bee County
Attention: Jaime Castillo, HR Specialist
105 W. Corpus Christi, St., Room 305
Beeville Texas 78102
(P) 361-621-1550, Opt. #9
(F) 361-492-5986
(E) jaime.castillo@co.bee.tx.us

BEE COUNTY
ACCIDENT/INJURY REPORT

Department: _____ Soc. Sec. Num: _____

Name of Person Injured: _____ Date of Birth _____

(Check One) Employee ____ Student ____ Client ____ Volunteer ____ Visitor ____

Mailing address of Injured: _____

Marital Status: M S D No. Of Dependents Children _____ Spouse's Name _____

(circle one) Sex M F Injurer's Phone #: _____

Nature of Injury: _____ Part of Body Injured: _____

Witness(es) _____ Race: White Black Asian

Address where Injury Occurred: _____

Date of Accident: _____ Time of Injury/Accident: _____

Who was Notified: _____ There Phone #: _____

Does Injured Speak English ____ If not what Language: _____

Was Employee doing his job: Y N Date Lost Time Began: _____

Cause of Injury _____

(EX: Fall, Tool, Machine, ECT.)

Worksite Location of Injury (stairs,dock,ect.) _____ Ethnicity: Hisp. Nat.American Other

How & Why did Accident Occurred: _____

_____

_____

_____

Did Injured go for Medical Treatment: Y N if yes What Date: _____

Supervisor's Name: _____ Date Reported _____

Return to Work date/of expected: _____ Did Employee Die: Y N

Physician's Name: _____ City _____

Hospital _____ City _____

Phone Number _____ Return Visit Required: Yes No If Yes Date _____

_____ _____

Signature of Injured/Employee Date

_____ _____

Signature of Supervisor Date

Reported By: _____ Date: _____

Date forwarded to Human Resources _____ Date Received By H.R _____

Comments: _____

_____

_____

ORIGINAL TO HUMAN RESOURCES COPY TO SUPERVISOR

Please give the **"Workers' Compensation Authorization for Medical Attention"** form and the following documentation to the Injured Employee

Attachments For Employee :

1. **My Matrixx** – If you go to the doctor and he/she prescribes medication(s) for you, Please take this form with you to the Pharmacy they will use this to fill your prescription and bill Workers Comp

2. **Employee Rights and Responsibilities** – These are your rights and responsibilities as an injured employee (PLEASE READ);

3. **Bee County Authorization for Medical Attention** – Fill this form out, and give to the physician that you decide to go to for your Workers Compensation Care, so that they will know where to send all bills.

Our goal is to make this process as simple and smooth as possible for you and your department. If you have any questions please feel free to call the HR Department at 361-621-1550, Opt. #9

Thank You,

Jaime Castillo, HR Specialist
HR Department- Bee County

Texas Association of Counties
Risk Management Pool

P.O. Box 160120
Austin, TX

(800) 752-6301

Texas Association of Counties Risk Management Pool
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#:	10602730
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	014211
Days supply is limited up to 30 days for a new injury.	
myMatrixx Help Desk: (877) 804-4900	

Employee:

Texas Association of Counties Risk Management Pool 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. This form does not certify compensability or guarantee payment.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 4,680 pharmacies in Texas and 65,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

TO LOCATE AN APPROVED DOCTOR OR HEALTHCARE PROVIDER, PLEASE VISIT: WWW.PSWCA.ORG

IF YOU ARE DENIED MEDICATION(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.

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.

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

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 W**orkers' 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.**

BEE COUNTY
WORKERS' COMPENSATION
AUTHORIZATION FOR MEDICAL ATTENTION

To: Doctor/Medical Center:_____ Date:_____
Our Employee:_____ Who works in/at_____ has been
Sent to you concerning an on job injury_____
Type of Injury

Date of Injury/Accident:_____ Time left work:_____

Approved by:_____ Date:_____
Signature and Title

Since this appointment concerns a possible Workers' Compensation claim, please state your findings below and send all bills and narratives for this employee to:

Send Bill to: JI Companies
P.O. Box 160120
Austin, TX. 78716-0120
P. 512-427-2367
F. 512-346-9321

Send copy to: Bee County Human Resources
105 W. Corpus Christi St. Room 305
Beeville, TX. 78102 P.361-621-1550
F.361-492-5986

FOR PHYSICIAN'S USE ONLY

I have examined the above referenced employee and my findings are as follows:

_____

_____

_____

PHYSICIAN'S RELEASE

This employee:_____

___ Has been released to return to work this date without restriction.
___ Has been released to return to work without restriction on_____
Date
___ Has been released for limited duty work assignment on _____
Date
Restrictions:_____
Duration of restrictions: (Best Estimate)_____days.
___ Patient will return in_____days for follow-up at _____:_____ AM/PM
___ Is unable to return to work or limited duty_____ Full duty_____
___ Patient referred to personal physician or specialist for further evaluation. Please indicate personal physician/specialist.

_____

PHYSICIAN SIGNATURE:_____ DATE:_____

I hereby authorize the attending physician and/or medical center to disclose the information contained on this form concerning my injury/condition to my employer, and hereby release the attending physician and medical center form any liability arising from such disclosure.

EMPLOYEE SIGNATURE:_____ DATE:_____