LAFAYETTE SCHOOL CORPORATION

IF YOU ARE INJURED AT WORK

Report your injury immediately to your supervisor

If you need to seek medical care you must go to one of the facilities listed below:

Franciscan Working Well

3218 Daugherty Drive, Suite 140

Lafayette, IN 47909

765-502-4190

M – F: 7 am – 7 pm

FOR EMERGENCY CARE ONLY OR AFTER 7:00PM AND WEEKENDS.

Franciscan Health Emergency Department

1701 South Creasy Lane

Lafayette, IN 47905

765-502-4000

ALL FOLLOW UP APPOINTMENTS MUST BE APPROVED BY STATE AUTO.

FORMS MUST BE FILLED OUT AND RETURNED TO THE NURSE OR CONNIE SORENSEN WITHIN 8 HOURS OF THE INJURY.

IF YOU HAVE ANY QUESTIONS PLEASE CONTACT:

Connie Sorensen / Worker's Compensation Coordinator

765-771-6037 / csorensen@lsc.k12.in.us

2023-2024

WORKER'S COMPENSATION PROCESS FOR INJURED EMPLOYEES

WORKERS' COMPENSATION COORDINATOR: CONNIE SORENSEN 765-771-6037

conniesorensen@lsc.k12.in.us

EMPLOYEE INSTRUCTIONS

- Notify your supervisor and nurse immediately about any injury you might have.
- Fill out THE EMPLOYEE'S INJURY REPORT TO THE EMPLOYER, PART 1. At the bottom of the page is a row of boxes asking where you were referred to, please be sure to check one of these boxes and then sign and date the form.
- Fill out the AUTHORIZATION FORM and sign and date it and take this with you to give to the medical facility. The nurse will need to make a copy of this before you leave the building.
- INDIANA WORKER'S COMPENSATION FIRST REPORT OF EMPLOYEE INJURY FORM. Please fill out the EMPLOYEE INFORMATION SECTION and the OCCURRENCE/TREATMENT INFORMATION SECTION toward the bottom of the form.
- If there were any witnesses when you were injured please tell the nurse so she can have them fill out the WITNESS FORM.
- Be sure to read the **PROVIDER BILLING INFORMATION** and take this paper with you and give it to the medical provider.
- If you are needing to pick up any prescriptions for your work-related injury, please fill out your information at the bottom of the **PRESCRIPTION PROGRAM FORM** and give this form to the pharmacy.
- If you are seen by a medical provider and receive any paper work concerning your injury, we will need a copy of that also as soon as possible. The form from Franciscan Working Well is called a WORK STATUS SUMMARY.
- Fill out all the forms the same day of the injury if possible and if not then within 8 hours the forms will need to be turned into the nurse at your building. You can also drop the paper work off at Hiatt or email them to me directly. Please only return the forms listed below:
  THE EMPLOYEE'S INJURY REPORT TO THE EMPLOYER
  AUTHORIZATION FORM
  INDIANA'S WORKER'S COMPENSATION FIRST REPORT OF EMPLOYEE INJURY FORM
  WITNESS FORM
  WORK STATUS SUMMARY REPORT FROM THE DR. IS YOU RECEIVED ONE.
- **FIRST AID ONLY**: If the nurse and you agree that you have an injury that only needs first-aid, then you do not have to go see a medical provider. You will have to follow the same instructions on this sheet and turn in the forms listed above.
- **If you refuse to fill out all the proper paper work at the time of your injury you could be refused compensation for your medical bills and wage compensation if the injury was to need medical attention at a later date.**
- **If you are an hourly employee and you have to leave work for an appointment please clock out and in when you return . You will need to email or call me about your appointment times and I will put in your time in veritime and it will be designated as Worker's Comp. pay.**

ENCLOSED IS IMPORTANT INFORMATION REGARDING YOUR WORK INJURY:

RTW is the administrator for your employer's workers compensation claims. Please sign the enclosed authorizations ASAP and return to RTW in the enclosed envelope.

Your Claim Administrator is STATE AUTO. If you have any questions regarding workers' compensation benefits, your Claim Administrator can be reached at 1-800-789-2242.

Rights and responsibilities, for an accepted claim:

- If medical treatment is needed for your injury, your employer may have a designated medical provider. Please see your employer for information regarding this. If you need any special tests (MRI, CAT scan, etc.), x-rays, or referrals to specialists you may need prior authorization. Please contact your Claim Administrator.

- **A Physicians Report/workability must be completed at each medical appointment.** This form must be returned to your employer after each visit.

- We are concerned that your recovery be as swift as possible. We want to work with you to reach that goal. We will also cooperate with your medical providers to assist them in your recovery. **Your employer may provide transitional duty within any restrictions the doctor/chiropractor provides.**

- You will return to work as soon as you are medically able. If you are scheduled to work and you feel your injury or illness prevents you from going to work, please call your supervisor immediately. You should be seen by a physician the same day. **Lost- time benefits may be jeopardized if you do not have a written medical authorization from a physician for the same day.**

- Please submit bills from physicians, pharmacies, etc. to your employer. You may be entitled to receive reimbursement for mileage to and from medical appointments or for medications you've paid for with cash, credit or check. In order to consider reimbursement for these items, you must attach detailed receipts for any medications you've paid for as well as submitting a list of the dates of travel, to and from, reason for the trip and the round trip mileage.

Please note: "A person who submits an application, submits false information, files a claims, or requests payment from an insurer, with intent to defraud or helps to commit a fraud against an insurer is guilty of a crime".

INDIANA WORKER'S COMPENSATION FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R10 / 1-02)

Please return completed form electronically by an approved EDI process.

FOR WORKER'S COMPENSATION BOARD USE ONLY		
Jurisdiction	Jurisdiction claim number	Process date

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security Number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION

Social Security number	Date of birth	Sex ☐ Male ☐ Female ☐ Unknown	Occupation / Job title	NCCI class code

Name (*last, first, middle*)	Marital status	Date hired	State of hire	Employee status
	☐ Unmarried ☐ Married ☐ Separated ☐ Unknown			

Address (*number and street, city, state, ZIP code*)	Hrs / Day	Days / Wk	Avg Wg / Wk	☐ Paid Day of Injury ☐ Salary Continued

Telephone number (include area code)	Number of dependents	Wage	Per	☐ Hour ☐ Day ☐ Week ☐ Month
		$		☐ Year ☐ Other

EMPLOYER INFORMATION

Name of employer	Employer ID#	SIC code	Insured report number
Lafayette School Corporation	35-6002558	8211	

Address of employer (*number and street, city, state, ZIP code*)	Location number	Employer's location address (*if different*)
2300 CASON STREET LAFAYETTE, IN 47904	699127	
	Telephone number: 765-771-6085	
	Carrier / Administrator claim number	OSHA log number / Report purpose code: 00

Actual location of accident / exposure (*if not on employer's premises*): Bldng. name

CARRIER / CLAIMS ADMINISTRATOR INFORMATION

Name of claims administrator	Carrier federal ID number	Check if appropriate
State Auto Companies		☐ Self Insurance

Address of claims administrator (*number and street, city, state, ZIP code*)	☒ Insurance Carrier	Policy / Self-insured number
P.O. Box 390327 Minneapolis, MN 55439-9540		AC-IN-000106
Telephone number: 952-893-3700	Third Party Admin.	Policy period: From 04/08/2022 To 04/08/2023

Name of agent	Code number
THE MITCHELL AGENCY, LLC	0003243

OCCURRENCE / TREATMENT INFORMATION

Date of Inj. / Exp.	Time of occurrence ☐ AM ☐ PM ☐ Cannot be determined	Date employer notified	Type of injury / exposure	Type code

Last work date	Time workday began	Date disability began	Part of body	Part code

RTW date	Date of death	Injury / Exposure occurred on employer's premises? ☐ Yes ☐ No	Name of contact	Telephone number

Department or location where accident / exposure occurred	All equipment, materials, or chemicals involved in accident

Specific activity engaged in during accident / exposure	Work process employee engaged in during accident / exposure

How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.

Cause of injury code:

Name of physician / health care provider

Hospital or offsite treatment (*name and address*)

Name of witness	Telephone number	Date administrator notified

Date prepared	Name of preparer	Title	Telephone number
	CONNIE SORENSEN	W.C. COORDINATOR	765-771-6037

INITIAL TREATMENT

- ☐ No Medical Treatment
- ☐ Minor: By Employer
- ☐ Minor: Clinic / Hospital
- ☐ Emergency Care
- ☐ Hospitalized > 24 Hours
- ☐ Future Major Medical / Lost Time Anticipated

An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13).

Employee Injury Report to Employer Form

STATE AUTO INSURANCE®

NOTE: This is NOT the First Report of Injury!

INSTRUCTIONS: (1) Employee's Injury Report. Employee must notify their employer of any work-related injuries immediately. The injured employee and their supervisor completes Part 1 of this form. The supervisor (or safety representative) conducts investigation and completes Part 2 of this form. The form is provided to employer's Workers' Compensation manager (WCM). (2) First Report of Injury. The WCM completes the First Report of Injury (FROI) based on Employee's Injury Report (EIR) and any verbal clarification made by the injured employee. (3) Notifying State Auto. WCM submits FROI and EIR to State Auto. *** Please print clearly ***

Company Name:	

PART 1 - INJURED EMPLOYEE

Last Name:		First Name:		Middle Initial:	
Home Address:					
City:		Zip Code:		Phone:	( ) -

Date of Injury:		Day of Week:		Time of Injury:	am	pm
Date/time left work:		Date/time returned:		Lost Time?	Yes	No

Employee's explanation for injury:		Mark areas of injury below:	
		Front 	Back 
Name(s) of witness(es) to injury:			

PART 2 - SUPERVISOR (OR PERSON CONDUCTING INVESTIGATION)

Name & Title:	

Cause:

Burn, Scald, Exposure, Contact Injury	Fall, Slip or Trip	Rubbed or Abraded By	Striking Against or Stepping On
Caught In, Under, or Between	Motor Vehicle	Strain or Injury	Struck on Injured By (Kick, Stabbed, Etc)
Cut, Puncture, Scrape, Injured By	Repetitive Injury		

Type of Injury

No apparent Injury	Confusion	Cumulative Trauma (repetitive motion)	Puncture (e.g. needlestick)
Amputation	Crushing	Foreign Body (e.g., in eye, etc)	Sprain/Strain
Burn	Electrical Shock	Laceration/Cut	Other: _____

Was there a:	Finding/Comments:
Safety Rule Violation (explain)	
Other Violation (explain):	
Machine Malfunction (explain):	
Motor Vehicle Accident (explain):	
What actions are being taken to prevent recurrence?	

Date/Time Supervisor Notified:		Date/Time Accident Report Completed:	

Employee Referred to:	Designated Medical Provider: (Specify):	Hospital Emergency Room (Specify):	Declines medical care at this time

Supervisor's Signature:		Date:	
Employee's Signature:		Date:	

Witness Reporting Form

STATE AUTO INSURANCE®

Injured Employee			
Date of Injury:		Time of Injury:	
Witness Name:		Witness Phone:	( ) -

What is your relationship to the injured person?	
Did you actually witness the incident?	Yes No
If no, what time did you arrive at the scene?	
What did you see when you arrived?	

If you witnessed the incident, please describe what you saw happen:
In your opinion, what was the cause of the incident?
Do you know of any other people who may have witnessed this incident? If so, please state their names and contact information.

Witness Signature:	
Date:	

AUTHORIZATION FORM
FOR FILE REVIEW OR RELEASE OF COPIES

To: Workers' Compensation Board
State of Indiana
Records Section

I hereby authorize State Auto Companies administrator on behalf of your workers' compensation insurance carrier to review and/or receive copies of any or all parts of my Workers' Compensation Board Claim file, for any and all date(s) of injury, and any and all employers. The authorization is valid for six months from the date signed.

Employee Name:_____

Social Security Number:_____

Information concerning disability may not be used to make a job decision unless state or federal law requires use of this information. Any use or distribution of this information beyond that authorized by the subject of this data unless authorized by state or federal law is prohibited. Questions concerning use of disability information may be directed to the US Department of Health & Human Services on their site: www.hhs.gov/ocr/hipaa/.

_____
Signature

_____
Date

Prescription Program

INJURED WORKER

Step 1 — Complete the information requested in the bottom portion below

Step 2 — Present this form to your pharmacist along with the prescriptions for your work-related injury.

Pharmacy Options — First Script is available at over 61,000 pharmacies nationwide. To locate a nearby pharmacy, please call First Script Customer Service at: 1-800-791-2080.

Approved Medications — Please note that First Script is valid only for approved medications prescribed to treat your compensable work-related injury. You or your group health insurer, are financially responsible for any other prescriptions. The work-related injury carrier will determine the compensability of the claim.

PHARMACY INSTRUCTIONS

The injured worker's employer participates in First Script, a pharmacy benefit program administered by Medco. Call the First Script Help Desk, 24 hours a day, 7 days a week, at 1-800-791-2080 to verify employee eligibility, and receive Member ID Number. If the Member ID number is not listed on this form, please provide the claimant information indicated below to receive the Member ID Number. Please note the ID number on the form and return to injured worker. First Script claims are submitted electronically and electronic approval of the claim will be returned.

Pharmacy: You will not be required to submit any paperwork for this claim and payment is guaranteed for all electronically accepted claims.

Pharmacy: At the request of the work-related injury carrier for this customer, please use the following information to process all work-related prescriptions online.

Employee Name: _____

Date of Injury: ___ / ___ / _____

Employee SSN: ___ - ___ - _____

Code: **RTW-01**

Above information to be completed by injured worker or supervisor.

RX Program Administered By: **Express Scripts (ES)**

Group Number: **FSNCVTY**

Bin Number: **610014**

Member ID: _____

Continued on next page

Provider Billing

I. To the Employee

This sheet provides the information necessary for your medical facility to submit bills, reports or any other information they will need to process services provided to you. Please do not pay for any medical services directly billed to you as these cannot be reimbursed directly to you. Please take this, along with the Physician's Report, with you to your visit. The physician will complete the form, return it to you, and you are to immediately return it to your employer after your visit.

You may be reimbursed for prescriptions, particularly the first one(s) if so required. The first step is to call First Script at 800-791-2080 to find the closest networked pharmacy to you. At the pharmacy, advise the pharmacist upon prescription presentation that this will be handled by First Script. The pharmacist will call First Script at 800-791-2080 for approval and processing.

Your employer is covered for Workers' Compensation insurance by the following:

State Auto Insurance
P.O. Box 818057
Cleveland, OH 44181-9600

800-789-2242

Please give this information to your doctor or billing office at the time of first service in order to avoid issues or problems with bills.

II. To the Medical Services Provider

Please call 800-789-2242 with the patient's name, employer and date of claimed injury to obtain a claim number for billing and medical record submission.

- Bills and records, if applicable, should be submitted with the claim number to State Auto at the above address or by fax at 1-800-563-3364.
- Please allow 30 days for payment processing.
- Please be advised that we cannot reimburse the employee directly, so bills must be submitted to State Auto.

STATE AUTO®
Insurance Companies

RTW

Mileage and Expense Reimbursement Form

Under workers' compensation statutes you may be entitled to mileage reimbursement for trips to and from appointments for the doctor, diagnostic testing, and physical therapy.

Name: _____ **Claim Number:** _____
Date of Injury: _____ Employer: _____
Claim Rep Name: _____

Mileage

Date	From (address)	To (address)	Provider name	Round Trip Miles

Expenses

For prescription reimbursements you must submit a cash register receipt AND medication dispensing information provided by pharmacy.

DATE	Purchased from:	Prescriptions / Parking	Amount

Please send requested information to: State Auto Companies
PO Box 390327
Minneapolis, MN 55439-0327
Fax 800-563-3364, 952-893-3700

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.