

Workers' Compensation Insurance Coversheet

Instructional guide for FEIN Employer

Introduction and Purpose: As being the Fiscal Management Services, MRCI would like to provide as much assistance possible when one of your employees becomes injured while working. The purpose of workers' compensation insurance is to provide medical care and compensation to workers who become injured or disabled at work. It is extremely important to educate your employees on this benefit and explain that it is imperative they report all work-related incidents to you within 24 hours of the date of injury/illness. The purpose of this guide is to provide instruction to you and help you understand your role and responsibility.

FEIN Employer Role and Responsibility: When a work accident/injury occurs, it is your responsibility under workers' compensation law to report all incidents and inform MRCI of the event. MRCI files all reports on your behalf. You play a significant role in ensuring the incident is documented thoroughly and accurately. It is imperative that you maintain regular communication with the injured employee and provide MRCI's Human Resources Department with the appropriate forms in order to file with the insurance company (Nonprofit Insurance Trust). If claims are not submitted on time, penalties will apply.

Below is a brief list of steps during the claim process:

#1 When Incident Occurs

- In the event of an accident/injury, the employee must notify you as soon as possible and the employee must complete an incident report within 24 hours of the accident. Employer and employee must sign the back of the form. Please provide full detail of the incident and fax the ***Incident Report Form*** to Human Resources at 507-540-1230. If the employee does not require outside medical attention, you may disregard the rest of the forms included in this packet.

#2 Outside Medical Care (if needed)

- When an employee is injured and would like to seek outside medical treatment, please encourage them to do so. Let them know that their place of care is their choice as long as it is an approved provider. The employee must say to the provider that the injury is work-related and to contact Human Resources for insurance claim information. Direct dial for Human Resources: 507-386-5671. Employee must bring a return to work slip to the employer and the employer needs to send that from via fax to 507-540-1230.

#3 Employer Responsibilities

- Prior to the employee seeking medical care, provide the employee with ***1) Report of Work Ability*** form for the doctor to complete, ***2) Pharmacy/ Insurance information form*** (in case medication is prescribed) and ***3) The Minnesota workers' compensation system informational sheet.***
- Employer must fax the Report of Work Ability form and any other subsequent forms to Human Resources 507-540-1230.

#4 Employee Responsibilities

- Complete incident report and submit to employer. Make sure to provide as much detail as possible and obtain necessary signatures.
- Schedule a visit at medical facility (if wanting to seek treatment).
- Fill prescriptions, if applicable.
- Submit Report of Work Ability form to the employer and faxes a copy to Human Resources at 507-540-1230. Employee must follow any and all restrictions.
- Continue to attend follow-up visits until employee is released of their restrictions and has reached maximum improvement.

If you have questions regarding this process, contact Human Resources at 507-386-5671.



INCIDENT/ ACCIDENT REPORT FORM

Use black ink - NO WHITEOUT

Section 1- Completed by Employee/ Worker

Legal Name of Person Involved: _____ Date of Report: _____
 Date of Incident/ Accident: _____ Time of Incident/ Accident: _____ am/pm
 Witnesses: Name _____ Phone: (____) _____
 Name _____ Phone: (____) _____
 Specific Location and Address of Accident/Injury: _____

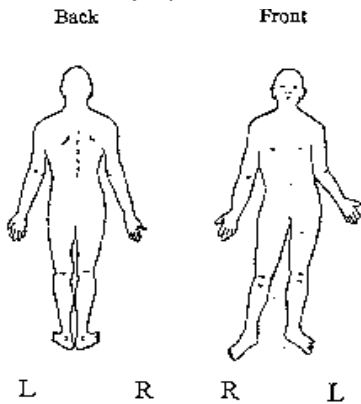
INCIDENT/ACCIDENT

Describe the incident/accident. Use facts and specific detail to describe the incident. (Include what was happening prior to the incident, response to the incident and effect on the person):

Action taken to prevent re-occurrence:

INJURIES Yes No **** If there are *NO* injuries, please go to Section 3 and 4, if applicable. If injury requires *outside* medical attention please call Human Resources immediately and fill out Section 2.

Circle site of injury:



Nature of Injury:

- Arrived with Injury Abrasion
- Bite Burn
- Bruise(s) Cut/Laceration Puncture
- Other _____

Identify First Aid Provided: _____

Does injury require medical attention (tetanus shot, stitches, etc.)? Yes No

Was blood or OPIM present? Yes No

Did the First Aid Provider wear gloves? Yes No

First Aid Provider: self Other _____

EXPOSURE INCIDENT

This is is not an exposure incident. If it is, contact MRCI immediately at 1-800-829-7110 for further instructions.

Health Care Professional notified immediately and Exposure Incident Report form completed N/A Yes

By Whom: _____ Date: _____



INCIDENT/ ACCIDENT REPORT FORM- Continued

Use black ink - NO WHITEOUT

Section 2 - Completed by Employee/ Worker or Supervisor ONLY if incident/accident involved outside medical treatment

OUTSIDE MEDICAL TREATMENT * Please send any doctor's notes or medical treatment regarding this injury to H.R.*

Date of Initial Visit to Medical Provider: _____ Name of Treating Physician/Name of Facility: _____

Address of Facility: _____

Time Employee began work on day of injury: _____ Date of First Day of Lost Time: _____

Supervisor who first received knowledge of injury _____

Date Returned to Work: _____ Please describe injured employee's normal work schedule: _____

Section 3 – Please Sign

SIGNATURES

Signature and Title of Person Completing form Date

Signature of Supervisor/Team Leader/Counselor Date

Signature of Program Manager Date

Signature of Safety Coordinator Date

Safety & Health Investigation completed: Yes No

Report of Work Ability

See Instructions on Reverse Side



DO NOT USE THIS SPACE

PRINT IN INK or TYPE

Enter dates in MM/DD/YYYY format.

This form must be provided to the employee.
 (Minn. Rules 5221.0410, subp. 6)

NOTICE TO EMPLOYEE: YOU MUST PROMPTLY PROVIDE A COPY OF THIS REPORT TO YOUR EMPLOYER OR WORKERS' COMPENSATION INSURER, AND QUALIFIED REHABILITATION CONSULTANT IF YOU HAVE ONE.

WID or SSN	DATE OF INJURY
EMPLOYEE	
EMPLOYER	
INSURER/SELF-INSURER/TPA NPIA, INC	
INSURER CLAIM NUMBER	

Date of most recent examination by this office _____

Select the appropriate option(s) below and fill in the applicable dates.

1. Employee is able to work without restrictions as of _____ (date)
2. Employee is able to work with restrictions, from _____ (date) to _____ (date)

The restrictions are:

3. Employee is unable to work from _____ (date) to _____ (date)

The next scheduled visit is: as needed OR _____

NAME (Type or Print)			SIGNATURE		DEGREE
ADDRESS			STATE	LICENSE #/REGISTRATION #	
CITY	STATE	ZIP CODE	PHONE # (include area code)		DATE SIGNED

INSTRUCTIONS FOR COMPLETING REPORT OF WORK ABILITY

Each health care provider directing the course of treatment for an employee who alleges to have incurred an injury on the job must complete a Report of Work Ability within 10 days of a request for a Report of Work Ability from the insurer, or at the applicable interval (Minn. Rules 5221.0410, subp. 6):

1. every visit if visits are less frequent than one every two weeks;
2. every 2 weeks if visits are more frequent than once every two weeks, unless work restrictions change sooner; and
3. upon expiration of the ending or review date of the restrictions specified in a previous Report of Work Ability.

The Report of Work Ability must either be on this form or in a report that contains the same information. The Report of Work Ability must:

- Identify the employee by name, social security number and date of injury.
- Identify the employer at the time of the employee's claimed work injury.
- If known, identify the workers' compensation insurer at the time of the claimed injury, or the workers' compensation third party administrator. Also indicate this workers' compensation payer's claim number.
- Indicate the date of the most recent examination by this office. The Report of Work Ability should be completed based on this evaluation.
- Identify the appropriate option which best describes the employee's current ability to work by checking box 1, 2 or 3.
 1. If the patient is able to work without restrictions, fill in the beginning date.
 2. If the patient is able to work with restrictions, fill in the date any restriction of work activity is to begin and the anticipated ending or review date. Describe any restrictions in functional terms (e.g., employee can lift up to 20 pounds, 15 times per hour; should have 10 minute break every hour).
 3. If the patient is unable to work at all, fill in the date the restriction of work activity is to begin and the anticipated ending or review date.
- Indicate the date of the next scheduled visit or indicate that additional visits will be scheduled as needed.
- Identify the health care provider completing the report by name, professional degree, license or registration number, address and phone number.
- Include the signature of the health care provider and date of the report.

The health care provider must provide the Report of Work Ability to the employee and place a copy in the medical record.

If you have questions, please call the claim representative or the Department of Labor and Industry, Workers' Compensation Division at (651) 284-5030 or 1-800-342-5354.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.



21034 Heron Way, Suite 107
 Lakeville, MN 55044
 Phone: 952.469.5963
 claims@npiainc.com

NOTICE TO INJURED WORKER & PHARMACIST:

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 processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438**.

Injured Worker's Name: _____ SS#: _____
 Date of Injury: _____

INJURED WORKER INSTRUCTIONS:

On your first Pharmacy visit, please give this notice to any pharmacy listed on this insert to expedite the processing of your approved Workers' Compensation prescriptions, based on the parameters established by Nonprofit Insurance Trust. 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 medications.

PHARMACIST 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: RXFFWC8573370
 Member ID: See below to generate ID

TO GENERATE MEMBER ID:

The Injured Worker's 9-digit Social Security Number **plus** the 8-digit Date of Injury will be used as their 17-digit Member Identification number when processing their First Fill Prescription: **XXXXXXXXXXMMDDYYYY**

There are over 65,000 Participating Pharmacies in the CorVel Network. Below is a sample listing. Call (800)563-8438 for a participating pharmacy near you.

CostCo Pharmacy	H.E.B. Pharmacies	Meijer Pharmacy	Smith's Food & Drug Centers
CVS	HyVee Pharmacy	Publix Pharmacy	Target Pharmacy
Dominick's Finer Foods	Ingles Pharmacy	Raley's Drug Center	Von's Pharmacy
Drug Mart	Kroger Pharmacy	Rite-Aid Pharmacy	WalMart Pharmacy
Fred's Pharmacy	Longs Drug Store	Safeway Pharmacy	Walgreens Pharmacy
Giant Eagle Pharmacy	Marc's Pharmacy	Sav-On Drug Store	Wegman Pharmacy
Giant Food Stores, LLC	Medicine Shoppe	Shoprite Supermarkets	Winn Dixie Pharmacy

NOTICE TO PROVIDER: Billing information for NPIA, Inc.

<p>E-Billing Information for Minnesota Workers' Compensation / Medical Bill Submission:</p> <p>CorVel Clearinghouse Electronic Billing- Connectivity issues and questions Clearinghouse Name: CorVel Contact: Christy M. Phone: 612-436-2520 or 877-703-4240 Fax: 1-866-450-9388 Email: stmn_clearinghouse@corvel.com</p> <p>CorVel Bill Review Customer Service- Questions on actual bill review services/reductions:</p> <p>Phone: 612-436-2428 E-mail: mn_billreview@corvel.com</p> <p>Nonprofit Insurance Trust (NPIA) Clearinghouse Payer ID: I1206</p>	<p><u>Nonprofit Insurance Trust (NPIA) Claims</u></p> <p>To obtain a claim number or claim adjuster contact information:</p> <p>Noreen Schonning, Claims Assistant Phone: 952-469-5963 ext. 103 E-mail: claims@npiainc.com</p>
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Minnesota Workers' Compensation System Employee Information Sheet

What does workers' compensation pay for?

- Medical care for the work injury, as long as it is reasonable and necessary
- Wage-loss benefits for part of your lost income (there is a three-calendar-day waiting period before these benefits start)
- Benefits for permanent damage or loss of function of a body part
- Benefits to your spouse and/or dependents if you die of a work injury
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer

How are workers' compensation benefits paid?

Your worker's compensation benefits are paid by an insurance company or your employer, if your employer is self-insured. State law sets the benefit levels. Please note: pursuant to statute, the insurer can obtain medical information specific to your work injury without your authorization.

If the insurer accepts your claim for wage loss benefits and you have been disabled for more than three calendar days.

- The insurer will send you a copy of the *Notice of Insurer's Primary Liability Determination* form stating your claim is accepted.
- The insurer must start paying wage-loss benefits within 14 days of the date your employer knows about your work injury and lost wages. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.

If the insurer denies your claim for wage loss benefits:

- The insurer will send you a copy of the *Notice of Insurer's Primary Liability Determination* form stating it is denying primary liability for your claim. The form must clearly explain the facts and reasons why the insurer believes your injury or illness did not result from your work.
- If you disagree with the denial, you should talk with the insurance claims adjuster who is handling your claim. Your employer's insurance company can answer most questions about your claim.
- Insurer name: **NPIA, INC.** Phone: **(952)469-5963**
- If you are not satisfied with the response you receive from the insurer and still disagree with the denial, you should contact the Department of Labor and Industry at one of the numbers listed below to see what to do next.

If you have other questions or need more help, call the Minnesota Department of Labor and Industry Workers' Compensation Hotline:

Twin Cities and Southern Minnesota: (651) 284-5005 or 1-800-342-5354; TTY (651) 297-4198

Duluth and Northern Minnesota: (218) 733-7810 or 1-800-365-4584

Your call will be answered by experienced workers' compensation specialists, who can provide **instant and accurate information and assistance.**

Additional workers' compensation information is available on the department's Web site at:

www.doli.state.mn.us

Your employer is required by law to give you this information. This material can be made available in different formats, such as large print, Braille or on audiotape, by calling the numbers printed above.