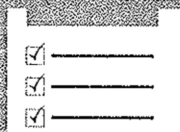
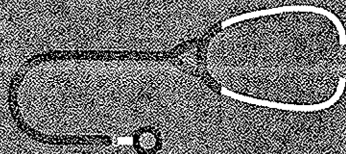
Effective Workers' Compensation Claim Handling


Accurate Reporting


Quality Medical Attention

How are you doing?
Excellent Communication

EMPLOYEE'S WORK INJURY REPORT

- Page 1 of 7: The injured employee is responsible for filling out this form at the time of injury (or as soon thereafter as practicable) and giving it to the Work Comp Contact. When filled out properly, this report should assist the Work Comp Contact in completing the First Report of Injury (FROI).
- This form does **NOT** replace the FROI – the FROI is required by the state to initiate a Workers' Compensation claim. Page 2 of 7 .

SUPERVISOR'S INSTRUCTIONS

- Page 3 of 7: Written instructions on the Supervisor's responsibilities following an injury/illness.

SUPERVISORS INVESTIGATION REPORT

- Page 4 of 7: Provides the supervisor the opportunity to document his/her opinion of what happened, plus suggest ways to avoid future injuries and provide modified duty options.
  - ✓ This report is not available for the injured employee to view - it is simply put in their personnel file by the Work Comp Contact for future reference and given to claims adjuster.

PHYSICIAN AUTHORIZATION FORM FOR MEDICAL TREATMENT

- Page 5 of 7: The injured employee takes this completed form to the initial physician's appointment. It assists the clinic with billing and nature of injury; while providing medical provider direction for the employee (reminding employee NOT to use group health insurance since it is a potential work comp injury).

WORK RELATED INJURY/ILLNESS REPORT

- Page 6 of 7: The injured employee gives this form to the physician for completion at the appointment. The physician should then fax the completed form to the insured account and EMC claims adjuster (all fax numbers are included on this form).

Employee's Work Injury Report

The injured employee is responsible for answering all questions on the Employee's Work Injury Report accurately and in detail. This will make the processing of your claim both accurate and timely. This completed report should be given to the workers' compensation contact within 24 hours of your work-related injury.

THIS FORM DOES NOT REPLACE THE FIRST REPORT OF INJURY (FROI).
THE FROI IS REQUIRED BY THE STATE TO INITIATE A WORKERS' COMPENSATION CLAIM.

Personal

Name ______ Social Security Number ______
Address ______ Birth Date ______ Sex M ☐ F ☐
City, State ______ Zip ______ Telephone ______
Married ☐ Single ☐ Number of Dependents ______ Home/School ______
Family Physician ______ Telephone Number ______
Are you currently entitled to Medicare Benefits? Yes ☐ No ☐ Medicare #(HICN) ______
Have you applied for Medicare or SSDI? Yes ☐ No ☐ Pending ☐ Rejected ☐

Employment

Job Title ______ Employment Date ______
Salary/Hourly Rate ______ Hours Worked Per Day ______
Building Location ______ Time Work Day Begins ______

Injury/Illness

Date of Injury ______ Time of Accident ______
Where in the facility/job site did this injury occur? ______
What were you doing when injured? ______
How did the injury occur? ______

Describe the injury or illness in detail and indicate the part of the body affected. (Designate right or left if appropriate.)

______

Any previous similar injury? If yes, explain. ______
Was this injury witnessed? If so, by whom? ______
Did you lose time from work? Yes ☐ No ☐ Date(s) missed ______
Have you returned? Yes ☐ No ☐ If yes, what was the date? ______

Treatment

Medical Facility ______
Diagnosis/Care Prescribed ______

Contact

When you return to work, you must call Patti Schauf at (608) 326-3715 and notify your assigned claims adjuster.

Employee's Signature (PRINTED) ______ Date ______

Employee's Signature ______

Form completed by injured employee (as soon after the injury as possible) and given to Workers' Comp. contact

EMC Insurance Companies

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Fatal Injuries: Employers subject to ch.102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee.
Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department.
Electronic Reporting Requirement: All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to the Imaging Fax Server number on this form.

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
http://www.dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].
(Please read the instructions on page 2 for completing this form)

EMPLOYEE

Employee Name (First, Middle, Last)	Social Security Number	Sex	Employee Home Telephone No.
	- -	☐ M ☐ F	( ) -

Employee Street Address	City	State	Zip Code	Occupation
			-	

Birthdate	Date of Hire	County and State Where Accident or Exposure Occurred?

EMPLOYER

Employer Name	WI Unemployment Ins. Acct No.	Self-Insured?	Nature of Business (Specific Product)
PRAIRIE DU CHIEN SCHOOLS	2X7731303	☐ Yes XX No	SCHOOL DISTRICT

Employer Mailing Address	City	State	Zip Code	Employer FEIN
800 E. CRAWFORD	PRAIRIE DU CHIEN	WI	53821	39-6004016

Name of Worker's Compensation Insurance Co. or Self-Insured Employer	Insurer FEIN
EMC 16455 W. BLUEMOUND RD.,P.O.BOX 327, BROOKFIELD,WI 53008	-

Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer	TPA FEIN
	-

WAGE INFORMATION

Wage at Time of Injury	Specify per hr., wk., mo., yr., etc.	In Addition to Wages, Check Box(es) if Employee Received:	
$	Per:	☐ Meals ☐ Room ☐ Tips	No. of Meals/wk. No. of Days/wk Avg. Weekly Amt. $

Is Worker Paid for Overtime? ☐ Yes ☐ No If Yes, After How Many Hours of Work Per Week?

For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks.

No. of Weeks:	Gross Amount Excluding Tips: $	If Piece-Work, No. of Hrs. Excluding Overtime:

	Start Time	Hours Per Day	Hours Per Week	Days Per Week
Employee's Usual Work Schedule When Injured:	: ☐ AM ☐ PM			
Employer's Usual Full-Time Schedule for This Type of Work at Time of Employee's Injury:				

Part-Time Employment Information:	Are there Other Part-Time Workers Doing the Same Work With the Same Schedule? ☐ Yes ☐ No If yes, how many?	Number of Full-Time Employees Doing The Same Type Of Work:

INJURY INFORMATION

Injury Date	Time of Injury	Last Day Worked	Date Employer Notified	
	: AM : PM			☐ Date Returned to Work ☐ Estimated Date of Return

Did Injury Cause Death?	Date of Death	Was This a Lost Time or Other Compensable Injury?	Did Injury Occur Because of:
☐ Yes ☐ No		☐ Yes ☐ No	☐ Substance Abuse ☐ Failure to Use Safety Devices ☐ Failure to Obey Rules

Was Employee Treated in an Emergency Room? ☐ Yes ☐ No Was Employee Hospitalized Overnight as an In-Patient? ☐ Yes ☐ No

Name and Address of Treating Practitioner and Hospital:

Case Number from the OSHA Log:

Injury Description - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved.

What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred)

What Was The Injury or Illness? (State the Part of Body Affected and How It Was Affected)

Report Prepared By	Work Phone Number	Position	Date Signed
	( ) -		

 SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT

SUPERVISOR'S INSTRUCTIONS

Assisting the Injured Employee

1. An employee who is injured at work must immediately report the incident to their supervisor.
2. The supervisor is required to:
   - Obtain immediate medical attention for the injured worker: Call the physician or medical facility prior to the employee's arrival, alert the staff of the injury/illness and approximate arrival time;
   - Follow company requirement for reporting job related injuries and illnesses;
   - Complete an incident investigation report.
3. The supervisor and injured worker review information received from the doctor and jointly determine if appropriate work is available.
4. Following an injured workers' return to work, the supervisor or the workers compensation contact monitors the injured workers' progress to assure that restrictions are carefully followed and assist to resolve any difficulties.
5. The injured worker must immediately report any difficulties with performing assigned work. Supervisor and injured worker work to address the problem.

The Investigation Report

The purpose of this form is to determine what actions are needed to eliminate or control the hazards that have caused the accident. The information gathered will guide your staff in developing safety consciousness and knowledge of safe conditions and safe work methods. If you are not aware of the circumstances surrounding the injury, you should consult with the employee in order to complete the investigation report accurately.

The statements made in this report are very important and should not contain phrases as "Employee should be more careful." As the supervisor, you should make the appropriate corrective recommendations for each accident such as "Notified the appropriate employee to place caution signs in the area when floors are wet."

After you complete the investigation report, return it to the workers' compensation contact within 24 hours of the employee's work-related injury.

If you have any questions or concerns, call Patti Schauf at (608) 326-3715.

SUPERVISOR'S INVESTIGATION REPORT

Name of Injured Employee:	Date:
Job Title and Department:	
Date and Time Of Injury:	Type of Injury:
Medical Treatment Center:	

What was the employee doing when injured? Where in the facility / job site did the accident happen?

____

Describe what happened: ______________________________

____

____

____

What corrective steps will be done (or could be done) to prevent recurrence? ______________

____

Was the employee working at designated job? ☐ Yes ☐ No

Is there modified duty available for the injured worker? ☐ Yes ☐ No

Has the injured employee returned to work? ☐ Yes ☐ No If so, what date? __________

______________________________ ______________

Supervisor's Signature Date

______________________________ ______________

Reviewed by Workers' Compensation Coordinator Date

Comments:

Return completed form within 24 hours of the accident to Patti Schauf.

Form completed by the supervisor of the injured employee and saved in the injured employee's file

EMC Insurance Companies

PHYSICIAN AUTHORIZATION FORM FOR MEDICAL TREATMENT

Injured Employee's Name:	Date:
Company Name & Address: PRAIRIE DU CHIEN AREA SCHOOL DISTRICT POLICY #2X77313 800 E. CRAWFORD ST. PRAIRIE DU CHIEN, WI 53821	Supervisor:

Do Not Use Your Group Health Membership Card if this injury/illness was sustained while working or acting in an official capacity for this company.

The following facility the preferred workers' compensation treatment center. Taking this Physician's Authorization Form with you will assist the staff in your care and in processing your medical bills correctly. You should call or have someone call for you to let the physician or clinic know you are on your way for medical treatment and the nature of the injury or illness.

GUNDERSEN PRAIRIE DU CHIEN CLINIC
610 E. TAYLOR ST.
PRAIRIE DU CHIEN, WI 53821
(608) 326-6466

NOTE: Use of the provider listed is voluntary and choosing to use an alternate provider that is not listed will not affect your employee benefits under state workers' compensation laws.

For a SERIOUS INJURY OR ILLNESS (or any treatment that should not wait until clinic hours the next day) seek immediate treatment at the nearest emergency facility. Hospitals include, but are not limited to:

CROSSING RIVERS HEALTH
705 E. TAYLOR ST.
PRAIRIE DU CHIEN, WI 53821
(608) 357-2000

Send all EMC work comp medical bills directly to:
EMC Insurance Companies, PO Box 327, Brookfield, WI 53008-0327 Fax: 888-992-6125

If you have any questions regarding this procedure, please call Patti Schauf at (608) 326-3715.

Supervisor's Signature ______________________ Date ______________

Injured employee should take completed form to initial physician's visit

EMC Insurance Companies

Work Related Injury/Illness Report

PLEASE FAX IMMEDIATELY TO BOTH:
Prairie Du Chien School District Fax:
EMC Insurance Companies Fax: (888) 992-6125

Date of Service: ______________________

Patient Name: ______________________

Employer: PRAIRIE DU CHIEN AREA SCHOOL DISTRICT

Notified: ☐ Yes ☐ No

Diagnosis: Is condition work related? ☐ Yes ☐ No

Treatment Plan:

Medication(s): ______________________

Date of most recent examination by this office: __/__/____ (Month/Day/Year). The next scheduled visit is: ☐ as needed OR __/__/____ (Month/Day/Year).

1. ☐ Recommended his/her return to work with no limitations on ______ (Date).

2. ☐ He/She may return to work on ______ (Date) with the following limitations.

DEGREE	LIMITATIONS
☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met. ☐ **Light Work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls. ☐ **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying objects weighing up to 25 pounds. ☐ **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds. ☐ **Very Heavy Work.** Lifting objects in excess of 100 pounds with frequent lifting and/or carrying of objects weighing 50 pounds or more.	1. In an 8 hour work day, patient may: a. Stand/Walk ☐ None ☐ 4-6 Hours ☐ 1-4 Hours ☐ 6-8 Hours b. Sit ☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours c. Drive ☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours 2. Patient may use hands for repetitive: ☐ Single Grasping ☐ Pushing & Pulling ☐ Fine Manipulation 3. Patient may use feet for repetitive movement as in operating foot controls: ☐ Yes ☐ No 4. Patient is able to: (Frequently / Occasionally / Not at all) a. Bend ☐ ☐ ☐ b. Squat ☐ ☐ ☐ c. Climb ☐ ☐ ☐

OTHER INSTRUCTIONS AND/OR LIMITATIONS: ______________________

3. ☐ These restrictions are in effect until ______ (Date) or until patient is reevaluated.

4. ☐ He/She is totally incapacitated at this time. Patient will be reevaluated on ______ (Date).

Treating Facility Name: ______________________ (Please Print)

Physician's Signature: ______________________ Phone No: (___) ______

RELEASE OF INFORMATION AUTHORIZATION

I authorize the treating physician to release copies of my medical records including lab and x-ray reports to the above-named employer and the insurance company. I certify that I have received a copy of this report.

Employee's Signature: ______________________ Date: ____________

 Form completed by physician and faxed immediately to all parties listed in top, right-hand box.

EMC® Insurance Companies