MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE #

SIC CODE

EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)

Mississippi School Boards Workers' Compensation Trust
489 Springridge Road, Clinton, MS 39056
601-924-2001

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☑ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CorVel Corporation
200 East Capitol, Suite 1600, Jackson, MS 39201
800-929-5893

CARRIER FEIN

POLICY/SELF-INSURED NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX

☐ MALE (M)
☐ FEMALE (F)
☐ UNKNOWN (U)

MARITAL STATUS

☐ UNMARRIED/SINGLE/DIVORCED (U)
☐ MARRIED (M)
☐ SEPARATED (S)
☐ UNKNOWN (K)

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

OF DEPENDENTS

NCCI CLASS CODE

RATE

PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:

#DAYS WORKED WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT

NO MEDICAL TREATMENT (0) ☐
MINOR: BY EMPLOYER (1) ☐
MINOR CLINIC/HOSP (2) ☐
EMERGENCY CARE (3) ☐
HOSPITALIZED > 24 HRS (4) ☐
FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) ☐

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

SEE BACK FOR INSTRUCTIONS

Mississippi School Boards Association

WC Trust

A Workers' Compensation Program

msba

WORKERS COMPENSATION
FIRST NOTICE OF LOSS

EMPLOYEE

First Name _____

Middle Initial _____

Last Name _____

ADDRESS

and Street _____

City _____

State _____

Zip Code _____

Phone # _____

Date of Birth _____

Social Security# _____

EMPLOYEE INFO

Gender (check one):

Male _____ Female _____ Unknown _____

Date hired _____

Occupation/Job Title _____

Employment Status (check one):

Full Time _____ Part Time _____ Temporary _____

WAGE (To be completed by Central Office)

Rate (check one):

Day _____ Week_____ Month _____ Other _____

Did salary continue? (check one):

Yes _____ No _____

OCCURRENCE

Date of Occurrence _____

Time Employee Began Work:

_____ A.M. _____ P.M.

Time of Occurrence:

_____ A.M. _____ P.M.

Last Day Worked _____

Date Employer Notified _____

Date Disability Began (if applicable) _____

CONTACT PERSON

Local School:

First Name _____

Last Name _____

Phone # _____

Type of Injury/Illness _____

_____

Nature of Injury _____

_____

Part of Body Affected _____

_____

Did Injury/Illness occur on Employer's premises? (check one)

Yes _____ **No** _____

Department or location where accident or illness occurred.

_____

_____

_____

All equipment, materials, or chemicals Employee was using when accident or illness occurred.

_____

_____

_____

Specific activity the Employee was engaged in when the accident or illness occurred.

_____

_____

_____

Work process the Employee was engaged in when the accident or illness occurred.

_____

_____

_____

Cause of Injury/Illness _____

_____

_____

Date Returned to work _____

If Fatal, Give Date of Death _____

Were safeguard or safety equipment provided? (check one):

Yes _____ **No** _____

Were safeguards used? (check one):

Yes _____ **No** _____

TREATMENT

Healthcare Provider:

Name & Address _____

_____

_____

Hospital:

Name & Address _____

_____

_____

OTHER

Witness:

First Name _____

Last Name _____

Phone # _____

Date Administer Notified _____

Date Prepared _____

ADDITIONAL NOTES

_____

_____

_____

_____

_____

NOTICE OF PHYSICIAN CHOICE

Employee's Name: _____

Employer's Name: _____

Injury Date: _____

I am claiming to have sustained an injury involving my _____. (indicate part of body)

I am ☐ am not ☐ claiming that my medical condition is work related. (check one)

If work related:

I understand that under the Mississippi Workers' Compensation Law I have the right to choose one (1) physician to render treatment to me. I can either accept the physician to whom I am sent by employer or choose someone else on my own.

I also understand that any referral to any other doctor must be made by my one chosen physician.

I also understand that my employer (or workers' compensation carrier) must approve any physician change and that if I change doctors without their authorization, I will be responsible for the medical expenses for the unauthorized treatment.

With that understanding, I state as follows:

- ☐ I accept as my choice of physician my employer's tender of treatment by Dr. _____.

- ☐ I elect to choose my own physician to render treatment, and that choice is Dr. _____.

_____
Employee's Signature

_____
Date

Witnessed By: _____

_____

Copy to Employee, Employer and CorVel (within 24 hours)

WORKERS' COMPENSATION
EXAMINATION AND WORK STATUS FORM
Mississippi School Boards Association
Workers' Compensation Trust

To be Completed by Employer

Claimant _____ SS# _____

Address _____ Date of Birth _____

City & State _____ Zip Code _____

Job Title _____ Phone _____

School: _____

DATE & TIME OF ACCIDENT/INJURY _____

NATURE OF INJURY _____

Employee's Signature _____ **Date** _____

Authorized Signature _____ **Date** _____

PHYSICIAN TO COMPLETE

DATE OF SERVICE _____

CURRENT COMPLAINT _____

DIAGNOSIS _____

Work Status:

_____Temporarily Unable to Return to Work

_____Return To Work On _____

_____Restrictions As Follows _____

_____Return to Work No Restrictions

Date of Follow-up Appointment (if applicable) _____

PHYSICIAN'S SIGNATURE _____ **DATE** _____

PHYSICIAN'S ADDRESS _____

PHONE # _____

****PLEASE FAX FORM TO THE CLAIMS ADMINISTRATOR, CORVEL CORPORATION**
Fax Number: 1-866-434-4720 Telephone: 601-863-2740

To obtain a Pre-certification of Medical Necessity: Call 1-800-278-6602

HIPAA AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, authorize the health care providers identified in paragraph 2 below to disclose protected health information ("PHI") about me as described in this Authorization:

1. The information to be disclosed is all medical documentation, including but not limited to medical history, consultation, prescription, or treatment, copies of hospital records, radiology reports, test results, x-ray, MRI, CT Scan and myelogram films or plates, clinic notes, including diagnostic and prognosis related to my work- related injury of _____ ("work injury").

2. _____ and any other health care provider or facility who treats me for my work injury ("Identified Health Care Providers") may disclose the above-described information to CorVel Corporation and/or Vocational Case Manager or Medical Case Manager employed by CorVel Corporation.

3. This disclosure is made for the following purposes: As requested by the individual for workers' compensation purposes.

4. I understand that the Identified Health Care Providers are not conditioning my treatment, payment, enrollment, or eligibility for benefits on whether I agree to sign this authorization.

5. I understand that the information disclosed pursuant to this authorization may no longer be protected by the federal health privacy rule and may be subject to re-disclosure by the recipient.

6. I understand that I have the right to revoke this authorization in writing at any time by sending a letter to the Privacy Officer of the Identified Health Care Provider and that the effective date of my revocation will be the date the Privacy Officer receives it. I further understand that any revocation will be effective only to the extent that Identified Health Care Providers has not already taken action in reliance on this authorization.

7. This Authorization shall expire twelve months from the date of signature.

_____
Name of Employer (School)

_____
Printed Name (Employee)

_____ _____
Signature (Employee) Date

_____
Witness

_____ _____
Relationship to Employee (supervisor, Principal etc) Date

Mississippi School Boards Association
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Injured Worker's First Fill Prescription Information Sheet

PLEASE TAKE THIS INSERT TO THE PHARMACY

Injured Worker Name: _____ Date Of Injury: ___/___/___ Social Security #:_____

Dear Injured Worker,

On your first visit, please give this notice to any pharmacy listed on this insert to expedite the processing of your approved Worker's Compensation prescriptions, based on the established parameters by **MISSISSIPPI SCHOOL BOARDS ASSOCIATION**. With the CorVel CorCareRx program, you do not need to complete any paperwork or claim forms. Simply present this CorVel First Fill Prescription Information Sheet to the pharmacy. You should not incur any costs or co-payments at the pharmacy and will allow up to a **14** day supply of medications.

Dear Pharmacist,

Below is a portion of the information required to process an online claim to CorVel on behalf of **MISSISSIPPI SCHOOL BOARDS ASSOCIATION**. **Please contact the CorVel Biloxi office 800-599-5825** for additional processing and approval information specific to the injured worker.

BIN: 004336 **PCN:** ADV **RxGrp:** RXFFWC604

Pharmacies can contact CorVel **Pharmacy Help Desk** at **800-599-5825 or 800-563-8438** for after hours, assistance with claims processing. The Pharmacy Help Desk is available Monday through Friday, 8am to 11pm eastern time for your convenience.

There are 70,000 Participating Pharmacies in the CorVel Network. Below is a sample listing.

Bi-Lo Pharmacy	Fred's Pharmacy	Marsh Drugs	Safeway Pharmacy
Brooks Pharmacy	Fry's Pharmacy	Medical Arts Pharmacy	Sav-On Drug Store
Brookshire Pharmacy	Giant Eagle Pharmacy	Medicap Pharmacy	Schnuck's Pharmacy
City Market Pharmacy	Happy Harry's	Medicine Shoppe	Shop N' Save
CostCo Pharmacy	H.E.B. Pharmacies	Meijer Pharmacy	Snyder's Drug Store
CVS	Hy-Vee Pharmacy	Minyard Pharmacy	Target Pharmacy
Discount Drug Mart	Ingles Pharmacy	NeighborCare	Thrifty Drug Store
Drug Mart	Kash N' Karry	Osco Drug	Tom Thumb Pharmacy
Duane Reade	Kerr Drug	Pathmark Pharmacy	United Drugs
Fagan Pharmacy	King Soopers	Payless Pharmacy	Von's Pharmacy
Family Drug	K-Mart Pharmacy	Price Choppers	Wal-Mart Pharmacy
Farmer Jack	Kroger Pharmacy	Publix Pharmacy	Walgreens Pharmacy
FarmFresh	Longs Drug Store	Raley's Drug Center	Wegman Pharmacy
Food Town	Marc's Pharmacy	Rite Aid Pharmacy	Winn Dixie Pharmacy

CORVEL