West Virginia

BRICKSTREET INJURY KIT

POLICY # WCB1025339

COMPANY NAME

CONTACT PERSON AND NUMBER

JURISDICTION

BRICKSTREET INJURY KIT SUPERVISOR CHECKLIST

Secure proper medical care for your employee and inform them if modified/ light duty work is available.

Follow your company's procedure to report the injury. If you are not aware of the procedure, call your supervisor.

Give this envelope to your employee and ensure they complete the enclosed forms.

Report the injury to BrickStreet within 24 hours using one of the following methods:

- **Telephone:** Call 866.45BRICK (866.452.7425), select "policyholder" and option 1 (This is the quickest and most convenient option)
- **Internet:** File electronically through StreetConnect; contact your agent or BrickStreet's Customer Service Unit for information about becoming a StreetConnect user
- **Email:** Send an email with the completed First Report of Injury as an attachment to ClaimsIntake@brickstreet.com; visit the specific jurisdiction's website to obtain the First Report of Injury form
- **Fax:** Send the completed First Report of Injury to 877.293.5513 or 304.941.1151; visit the specific jurisdiction's website to obtain the First Report of Injury form

If you have a StreetConnect account, you also can click the Virtual Claims Kit link, choose the appropriate carrier and jurisdiction and locate the correct form.

INJURED EMPLOYEE CHECKLIST

Report all injuries to supervisor
(Alabama, Georgia, Indiana, Iowa, Kansas, Missouri, North Carolina, Pennsylvania, South Carolina, Tennessee and Virginia allow your employer to either choose your physician or provide you with a list of approved physicians)

Obtain either a full-duty release or a completed Physician Statement of Physical Capabilities form from the doctor (if released for light/modified duty)

If released to return to work, return on your next scheduled work day with either your full-duty release or the Physician Statement of Physical Capabilities form

If not released to return to work, you must telephone your supervisor within one business day and provide:

- Physician's name, address and phone number
- Date of your next scheduled doctor appointment

Return Incident Report to your supervisor upon return or within 24 hours

Your Business. Your People. You're Covered.®

866.452.7425 • brickstreet.com

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...

TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

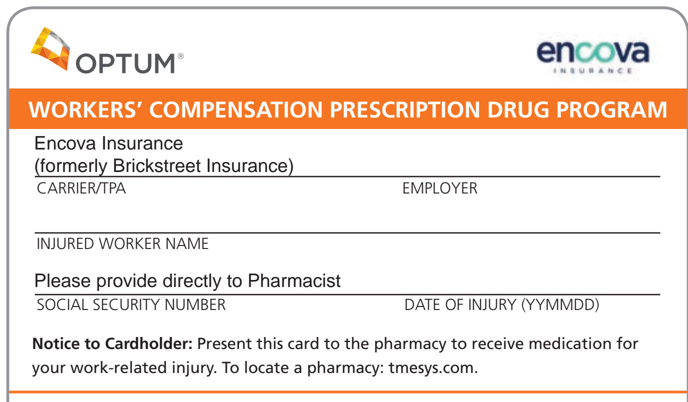
If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426



OPTUM® encova INSURANCE

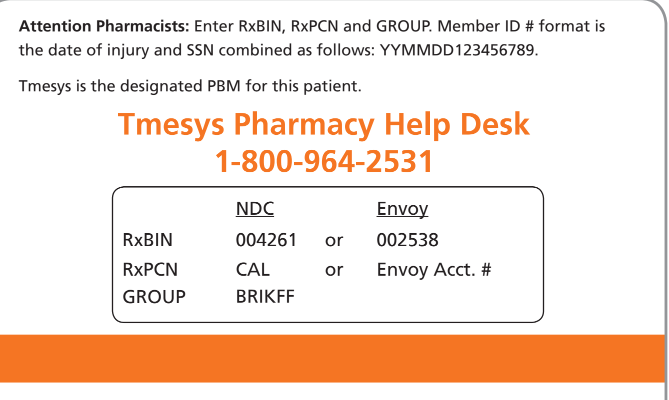
WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Encova Insurance
(formerly Brickstreet Insurance)
CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.



Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	BRIKFF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."

Medical Records Release

TO: Any licensed physician, chiropractor, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or other organization, institution, or person that has any records or knowledge of my health, history, condition, or well-being

In accordance with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and other applicable federal and state privacy laws and regulations, I, ____
Claimant Name Claim #
hereby authorize the use or disclosure of my individually identifiable health information described below to **BrickStreet Insurance Companies, P.O. Box 3151 Charleston, WV 25322**.

For purposes of this Authorization, individually identifiable health information shall mean: Any and all of my personal health information created, received or obtained, including any medical or dental records, x-ray or radiology films, pathology materials, MedFlight reports, insurance-related documents and benefit forms, or any other medically-related record or item that relates to my physical health or condition, the provision of health care to me, or the payment for my care, as the foregoing information relates to the assessment, treatment, or recordation of history related to any injury to me or any disease that affects me regardless of the time or cause of the onset of said injury or disease.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, psychological or psychiatric treatment, social services counseling, communicable diseases or infections, tuberculosis and hepatitis. Such records will be released through this authorization unless otherwise indicated. **Do not release any of the following information if an “x” appears before the description.**

__HIV/AIDS __Behavioral Health __Drug & Alcohol __Genetic History

I further authorize Recipient to use, disclose, or re-disclose any and all of my above-described health information and to make copies thereof for purposes of evaluating and administrating an insurance claim I have filed with Recipient. I understand that my health information may be re-disclosed by Recipient and may then no longer be protected by any applicable federal or state privacy laws or regulations.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Recipient at the address listed above. I understand that my revocation will only be effective after it is received by Recipient and that the revocation will not apply to information that has already been released in response to this authorization.

This authorization shall expire on: ___/___/____. If no date is specified, this authorization shall expire one year from the date it is signed. Any disclosures made prior to my revocation or prior to the expiration of this authorization will not be affected by my revocation or by the expiration of this authorization.

I understand and agree that a photocopy or electronically reproduced copy of the original of this authorization shall have the same effect as an original.

________________________________ ________________________
Signature of Individual Date

________________________________ _____/_____/____________
Social Security Number Date of Birth

____
Signature of Personal Representative, Estate Representative, or Guardian (Provide documentation of authority to act for individual)

medr [07/13]

Incident Report

To be completed by injured worker immediately following incident

WHEN

Date of incident:	Time of incident:
Was incident reported immediately to supervisor? ☐ YES ☐ NO	If not, please explain:

WHO

Employee name:		Job title:
Department:	Age:	Length of employment:
Names of witnesses (attach witness statements separately, if available):		

INJURY

Describe how your injury occurred (specify the cause, what you were doing, and equipment/objects involved):	
Nature/extent of injuries (include body part injured):	
Exact location where accident occurred (collect and include photographs):	
Was first aid administered? ☐ YES ☐ NO	
Did you see a doctor about your injury? ☐ YES ☐ NO	If yes, please list the following information:
Doctor's name:	Doctor's phone number:
Date of visit:	Time of visit:

CAUSES

Direct cause of injury (event that directly caused injury):	Was a third party involved?
	Was equipment involved in (or did it cause) the injury? ☐ YES ☐ NO

SUGGESTIONS

What could have been done to prevent this injury?

SIGNATURES

Employee Signature	**Date**
Supervisor's Signature	**Date**
Witness Signature(s)	**Date**

Return this form to your supervisor.

Physician Statement of Physical Capabilities

Return completed form to:

BrickStreet Insurance
P.O. Box 3151
Charleston, WV 25332-3151

Claimant Name	Claim Number	Date of Injury

Please complete this form after your examination of the patient. Indicate the patient's restrictions, if any, including modified hours, duties, environmental factors and any other information pertinent to this employee's healthy recovery and possible early return to work.

Medical Diagnosis

Work Postures (Work is performed in which postures? Please indicate frequency.)				
Standing	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
Sitting	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
Walking	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
Climbing	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
Kneeling	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
Pushing	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
Pulling	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
	(6 – 8 hours a day)	(2 – 6 hours a day)	(0 – 2 hours a day)	

Please indicate the extent to which the employee can perform the following:
(N = Never, O = Occasionally, F = Frequently, C = Continuously)

Lifting / Carrying	N	O	F	C	**Activity**	N	O	F	C
10 lbs. or less					Bend				
11 – 20 lbs.					Squat				
21 – 40 lbs.					Kneel				
41 – 60 lbs.					Twist / Turn				
61 – 100 lbs.					Climb				
Pushing / Pulling					Crawl				
13 – 25 lbs.					Reach Above Shoulder				
26 – 40 lbs.					Type / Keyboard				
41 – 60 lbs.					**Driving**				
61 – 100 lbs.					Automatic				
100+ lbs.					Standard				
Upper Extremities	Yes		No		**Operate foot controls**	Yes		No	
Simple Grasping	☐ R	☐ L	☐ R	☐ L	**or motor vehicles**	☐ R	☐ L	☐ R	☐ L
Pushing / Pulling	☐ R	☐ L	☐ R	☐ L	Simultaneous	☐ Yes		☐ No	

Comments

Physician Name		Physician Telephone
Date released with above restrictions	Date released for full-duty work	
Physician Signature		Date

West Virginia Workers' Compensation Employees' and Physician's Report of Occupational Injury or Disease

For BrickStreet Use Only
Claim Number:
Team Assigned:

SECTION I - EMPLOYEE'S CLAIM INFORMATION

1. Name: Last	First		MI
2. Address:			3. Telephone: - -
City:	State:	Zip:	4. Social Security Number:
5. Date of Birth:	6. Sex: ☐ M ☐ F		7. Marital Status:
8. Date of Injury or Last Exposure:	Time: ☐ a.m. ☐ p.m.		9. Time you Began Work on Date of Injury: ☐ a.m. ☐ p.m.
10. Date you Stopped Working Due to Injury:			
11. Have you Retired? ☐ Yes ☐ No	If "yes," what was the date you retired?		
12. Employer's Name:		Supervisor's Name:	
Address:			
City:	State:	Zip:	Telephone: - -
13. Job Title / Description:			
14. Body Parts Injured:			
15. Describe How Your Injury Occurred (Specify the cause, what you were doing, and equipment / objects involved):			
16. Did Injury Occur on Employer's Property? ☐ Yes ☐ No Address where Injury Occurred:			
17. Please Identify Any Witnesses to Your Injury:			

I certify that the above is true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I hereby authorize any physician, chiropractor, surgeon, practitioner or other healthcare provider, any hospital, including Veterans' Administration or governmental hospital, and medical service organization, any insurance company, any law enforcement or military agency, any government benefit agency including the Social Security Administration, or any other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to the diagnosis, treatment and/or counseling for HIV/AIDS, psychological conditions, and/or alcohol or substance abuse, for which I must give specific authorization. A Photostat of this authorization shall be valid as the original.

Employee's Signature: **Date:** / /

SECTION II – ALL INFORMATION MUST BE COMPLETED BY INITIAL PROVIDER

1. Name of Physician / Hospital:		2. FEIN / Social Security Number:	
3. Address:			
City:	State:	Zip:	Telephone: - -
4. Date of Initial Treatment:		5. Date Patient May Return to Work:	

6. Have you advised the patient to remain off work 4 or more days?
☐ Yes If yes, indicate dates: from to
☐ No If no, is the patient capable of ☐ Full Duty ☐ Modified Duty If the patient is capable of returning to modified duty, specify any limitations/restrictions:

7. Condition is a direct result of:	☐ Occupational Injury?	☐ Occupational Disease?	☐ Non-Occupational Condition?
8. Did this injury aggravate a prior injury / disease? ☐ Yes ☐ No	If yes, explain:		
9. Description of injury or occupational disease:			
10. Body Part(s) Injured:		11. ICD10-CM Diagnosis Code(s) in order of severity:	
12. Name of Physician Referred to:		13. If the patient was hospitalized, where?	

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge I have been informed of my responsibilities under West Virginia Workers' Compensation Law and agree to abide by such in the administration of services provided thereunder. I understand the submission of false statements or billing may result in prosecution under state and federal law. I further agree to release any office notes/test results immediately to the employer or their representative.

Physician's Signature: **Date:** / /

General Instructions for Completing the BI-1,
"West Virginia Workers' Compensation Employees' and Physician's Report of Occupational Injury or Disease"

Please Read Carefully

BI-1, West Virginia Workers' Compensation Employees' and Physician's Report of Occupational Injury or Disease: To be completed by the claimant and the medical provider.

This form should not be used to file occupational pneumoconiosis or hearing loss claims.

To the Claimant: Section I of this form must be completed by you. **When you have completed this form, make a copy for your records and give a copy to your employer.** The initial medical provider is responsible for completing Section II of this form. If you do not receive a decision on your claim within **14 days** after submitting the form, contact BrickStreet Insurance. To be eligible for benefits, **a claim must be filed with BrickStreet Insurance within six months** from and after the injury or death. If you have any questions, you may contact BrickStreet at 1-866-452-7425 or visit our Web site at www.brickstreet.com.

To the Initial Medical Provider: Section II of this form must be completed by you. The timely provision of information regarding the claimant's condition is vital in deciding eligibility for benefits. Each answer should be as specific as possible. You should immediately send a copy of all records, office notes and test results regarding the claimant's exam to BrickStreet Insurance. **Please forward the original completed form to BrickStreet Insurance and provide a copy to the claimant.** If you have any questions, you may contact BrickStreet Insurance at 1-866-452-7425 or visit our Web site at www.brickstreet.com.

Special Instructions for Section I	
Question 8	This date is defined as either the date you were injured or the date you were last exposed if you are filing an occupational disease claim.
Question 13	Provide your specific job title and describe the duties of the job you are currently working.
Question 15	Please provide as much detail as possible and attach additional pages if space is needed.

Special Instructions for Section II	
Questions 1, 2	The group and FEIN are required by BrickStreet for billing purposes.
Question 8	Describe in detail what effect, if any, the claimant's previous health may have on this injury.

Please attach additional pages if space is needed and include any appropriate reports.

Return completed form to: **BrickStreet Mutual Insurance**
P. O. Box 3151
Charleston, WV 25332-3151

When completing this form, enclose attachments if additional space is needed.

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