SUPERVISOR'S INCIDENT PACKET INSTRUCTIONS

These instructions are for the supervisor who is receiving an employee's report of incident.

STEP 1: To complete the Incident Report you will need to request the employee to provide you with all information pertaining to their report of incident. The employee's responses will be documented as follows:

- Supervisor completes Sections 1 – 4
- **Employee must Circle Injured Area(s) and Initial**
- Employee completes Section 5
- Supervisor completes Section 6 – 8
- Supervisor completes Sections U – W
- Supervisor completes Sections X – Z
- Employee completes Section AA - AB

STEP 2: Review and explain each section of the COH On-The-Job-Injury Reference Sheet to the employee.

- The employee is to initial each section and sign the bottom of the sheet.
- You will complete and sign the bottom of the sheet.
- Give the employee the copy of the COH On-The-Job-Injury Reference Sheet that contains the employee number and date of injury.

STEP 3: The employee will complete and review the HIPAA Authorization for Disclosure of Protected Health Information.

- The employee will print their name in the space provided at the top of the document.
- The employee will review the document.
- The employee will sign and date the document.
- The employee will print their name, address, telephone and social security number at the bottom of the document.
- In the event an employee refuses to sign this document, the supervisor must note this on the document.
- **Keep this document for your records.**

STEP 4: Give the employee the PMOA Rx First Fill Information.

STEP 5: Upon completion of the Supervisor's Incident Packet, contact the Workers' Compensation Third Party Administrator.

- Call (832) 393-7233 (SAFE) then PRESS Option 1
- Use the completed Incident Report to answer all questions asked by the call taker.
- Document the reference # provided by the call taker in Section AC of the Incident Report.

STEP 6: Forward a copy of the completed forms to your assigned Designed Department Representative (DDR).

STEP 7: Ensure the appropriate Worker's Compensation codes are recorded on the employee's timecard, if necessary

- WCIL – Used to record time missed from work due to a work related injury.
- WCTD – Used to record time worked on Transitional Duty due to a work related injury.
- WCDR – Use after an employee returns to work, to record time missed from work to attend a medical appointment for a work related injury.

Supervisor's Incident Packet

Incident Report

On The Job Injury Reference Sheet

*** Supervisor reports the claim to
(832) 393-SAFE (7233), Options Press 1
within 24 hours! ***

HIPAA Medical Release Form

PMOA Medical Prescription Program

Go To: http://www.houstontx.gov/hr/risk_mgmt/wrkrs_cmpnstn.html
To obtain the Summary Workability Guidelines E.O. 1-33
(For Injured Workers) Booklet

Incident Report

1. Workers' Compensation Incident Type	☐ Record Only	☐ Medical	☐ Missed Work Day 1st Date Missed: _____	☐ Fatality

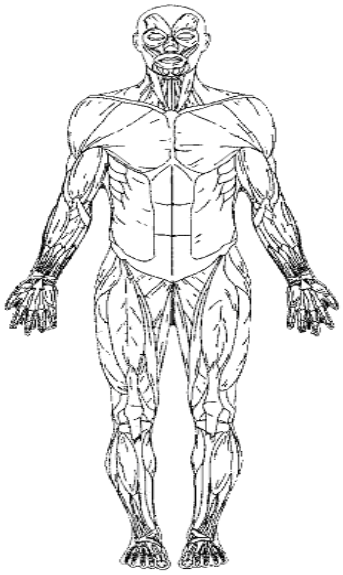
2. General Information			
A. Name of Injured Employee	B. Employee #	C. Date /Time of Incident	D. Date /Time of Reported
		___/___/___ ___:___ AM / PM	___/___/___ ___:___ AM / PM

E. Primary and Secondary Telephone Number for Employee Contact		F. Employee E-Mail Address	
1.	2.		
G. Emergency Contact Name	H. Emergency Contact Number	I. Primary Language Spoken by Employee	J. Full Work Week is
K. Length of Service in Current Position	L. Length of Service in Occupation	M. Supervisor to whom Incident was Reported	N. Supervisor Contact Number
___Years ___Months	_____Year _____Months		

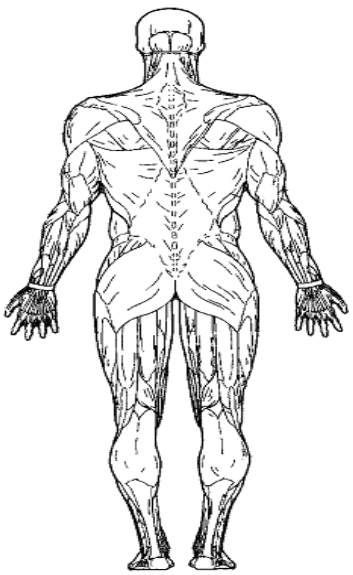
3. Medical Information	
O. Medical Treatment Requested	P. Name, Address And Telephone Number Of Treating Facility
☐ Yes ☐ No	

4. Witness Information	
Q. Witness	R. Witness Contact Number(s)

Circle injured Area(s)



Right Side **Left Side**



Left Side **Right Side**

Incident Report

5. Description of How and Why Incident/Illness Occurred (If Employee is unavailable, may be completed by Supervisor/Designee)

6. Nature of Injury: (Example: Laceration, Burn, Fracture)

7. Cause of Incident: (Please circle the appropriate box)

Cut, Punctured, Scraped	Lifting	Pushing or Pulling	Fall, Slip or Trip	Twisting	Person in Act of Crime
Motor Vehicle	Fall/Slip on Stairs	Repetitive Motion	Continual Noise	Struck or Injury By	Struck/Injured By Motor Vehicle
Contact with Hot Object or Substance	Absorption, Ingestion or Inhalation	Foreign Body in Eye	Struck/Injured By Animal or Insect	Strain By Using Tool or Machine	Stepping on Sharp Object
Struck/Injured By Falling or Flying Object	Fall/Slip From Liquid or Grease Spills	Hand Tool, Utensil; Not Powered	Powered Hand Tool; Appliance	Caught In, Under or Between	Fall/Slip From a Different Level
Struck/Injured By Fellow Worker, Patient	Contact with Electrical Current	Fall/Slip From Ladder or Scaffolding	Struck/Injured By Hand Tool or Machine in Use	Striking Against or Stepping On	Struck/Injured By Object Handled By Others
Struck/Injured By Object Being Lifted or Handled	Struck/Injured By Moving Parts of Machine	Welding Operations	Contact With Not Otherwise Classified	Other than Physical Cause of Injury	

8. Additional Incident Information	
S. Address Where Incident/Exposure Occurred	T. Location At Time Of Incident
U. Activity At Time Of Incident	V. Equipment Involved
W. Other Items/Tools Involved	

X. Signature of Person Completing Form	**Y. Employee ID# of Person Completing Form**	**Z. Date Form Completed**
AA. Employee Signature	**AB. Date Form Signed**	**AC. Reference #**

COH ON THE JOB INJURY REFERENCE SHEET

(Must be signed by the employee for confirmation of receipt)
For detailed employee benefits and responsibilities see your Summary Workability Guidelines E.O. 1-33 (For Injured Employee Booklet

_____ If emergency medical attention is required, your supervisor will accompany and/or direct safe transportation to the nearest medical facility.

_____ You have your choice of treating doctor. The minor emergency clinic or hospital attended at the direction of your supervisor is not considered your choice of treating doctor. Your doctor must abide by the Texas Department of Insurance – Division of Workers' Compensation Rules. Contact your assigned adjuster as soon as you are aware of your treating doctor's information or within 48 hours of incident as this is needed to authorize treatment.

_____ In this packet you have be given a sheet where you can obtain prescription medications, which have been found to be reasonable and related to your on-the-job-injury, at no cost to you.

_____ You must cooperate with investigation. Complete the incident form with your supervisor, answer supervisor and safety officer questions and expect a call from the Workers' Compensation Third Party Administrator within 48 hours of your injury to take a recorded statement.

_____ Any change in work status must immediately be communicated to your supervisor and adjuster to ensure that the proper benefits are initiated or stopped. This will prevent an overpayment causing hardship at time of mandatory reimbursement to the City.

_____ You must contact your adjuster after every doctor's or referral visit (this does not include PT visits), if unable to reach your adjuster insure that your message includes; current work status, treatment plan, next office visit date.

_____ If you have worked for the City of Houston for at least one year, have been physically present at work at least 1,250 hours during the previous twelve months, and your injury/impairment is considered a serious health condition, you will be placed on Family Medical Leave. Once a determination is made on your status, your Family Medical Leave Coordinator will contact you with additional information.

_____ Contact your Pension Representative to determine how Workers' Compensation Benefits affect your pension and retirement.

_____ You may be required to attend classes while on injury leave.

_____ You will receive as part of your injury packet contact information, salary continuation policy and quick reference part of the requirements under Executive Order 1-33. The complete Executive Order 1-33 can also be found on the City of Houston website.

_____ I agree that any overpayments paid in any form as well as any other City funds paid to me that should not have been paid to me may be deducted from my future earnings so long as such deductions do not reduce my earnings below minimum wage in any pay period in which such deductions are made. [NOTE: Failure to initial this section renders injured worker ineligible for salary continuation benefits.]

_____ Initialing here confirms that you have received a copy of this document.

_____

By initialing each bullet point and signing the bottom of this page you agree that your supervisor fully explained each point and that you have received your incident packet, your supervisor will keep your acknowledgement, which will be kept in your file.

Employee Number: _____ Date of Incident: _____

Employee Signature: _____ Today's Date: _____
Supervisor Signature: _____ Today's Date: _____

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Authorization for Disclosure of Protected Health Information

I, _____ [Your Name], authorize the disclosure of my protected health information as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below):

All healthcare providers who have provided healthcare services to me. All insurance carriers and/or Third Party administrators with whom I have filed claims.

2. I authorize the following person(s) and/or organization(s) to receive my protected health information as disclosed by the person(s) and/or organization(s) below.

City of Houston on behalf of: Third Party Administrator,

Texas Department of Assistive and Rehabilitative Services

3. Specific description of the protected health information that I authorize for disclosure (authorization to disclose psychotherapy notes must be separate):

Any and all records regarding my health, including medical histories, consultations, examinations, prescriptions, diagnosis, tests, reports or treatments.

I further specifically authorize the disclosure of psychotherapy notes, if any.

4. This information may be used by the carrier to evaluate, adjust, describe, or report matters about my health to persons entitled to receive this information.

5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) names above have taken action in reliance on this authorization.

6. This authorization expires on one year from the date of this authorization, or the date that my workers' compensation claim is finally closed, whichever occurs first.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

_____ _____

Signature Date

Name: _____ Last (4) of SSN: xxx-xx-_____ Date of Birth:_____

Address: _____

Telephone: _____

_____

Relationship or Authority of Personal Representative (if applicable)

City of Houston
Workers' Compensation
First Fill Program

EMPLOYER INSTRUCTIONS:

- SUBMISSION OF THIS FORM ACKNOWLEDGES THAT THE REPORT OF INJURY HAS BEEN FILED WITH CITY OF HOUSTON
- USING THE EXAMPLE BELOW COMPLETE THE TEMPORARY CARD ID

EMPLOYEE INSTRUCTIONS:

- FOR TEMPORARY ENROLLMENT PURPOSES ONLY, THIS FORM MUST BE PRESENTED TO YOUR LOCAL PHARMACY TO OBTAIN YOUR INITIAL PRESCRIPTION
- FOR QUESTIONS REGARDING YOUR BENEFIT PLAN, CONTACT PMOA'S CUSTOMER SERVICE DEPARTMENT AT 1-800-661-1494
- PLEASE NOTE: YOU MAY RECEIVE A PERMANENT RETAIL CARD IN THE MAIL FOR YOUR WORKERS' COMPENSATION INJURY

PHARMACY INSTRUCTIONS:

- USE THE INFORMATION BELOW TO PROCESS THE INTIAL PRESCRIPTIONS
- CONTACT 1-800-661-1494 FOR ANY PRIOR AUTHS OR TO OBTAIN THE PERMANENT MEMBER/GROUP ID FOR FUTURE FILLS

City of Houston
Temporary Work Comp Prescription Card
For PRE-AUTH Assistance call: 800-661-1494

Name: _____
Date of Injury: _____
ID: _____

SOCIAL SECURITY # + Date of injury (MMDDYY)
***must be 15 digits, please use 2 digit year**
(ID Example: *555555555081514*)

BIN: 004410 PCN: SCI GROUP: COHA

PLAN limit: Max Day Supply 14
Max $$ Amount $150.00

Disclaimer: It is important to note the issue will be determined by the claims department and the confirmation of this treatment/ service request is in no way intended as an endorsement, nor is it intended to interfere with the provider from the duties to adhere to any applicable practice standards.

If you need assistance, please contact the PMOA help desk at: **(800) 661-1494**