

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		
SIC CODE	EMPLOYER FEIN	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION # PHONE #

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	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO) CorVel Corporation 200 East Capitol, Suite 1600, Jackson, MS 39201 800-929-5893
		CHECK IF APPROPRIATE <input checked="" type="checkbox"/> SELF INSURANCE	
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 <input type="checkbox"/> MALE (M) <input type="checkbox"/> FEMALE (F) <input type="checkbox"/> UNKNOWN (U)	MARITAL STATUS <input type="checkbox"/> UNMARRIED/SINGLE/DIVORCED (U) <input type="checkbox"/> MARRIED (M) <input type="checkbox"/> SEPARATED (S) <input type="checkbox"/> UNKNOWN (K)		OCCUPATION/JOB TITLE
				EMPLOYMENT STATUS	
PHONE		# OF DEPENDENTS	NCCI CLASS CODE		
RATE	PER: <input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> OTHER: <input type="checkbox"/>	#DAYS WORKED WEEK	FULL PAY FOR DAY OF INJURY?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
	WEEK		DID SALARY CONTINUE?	<input type="checkbox"/> YES <input type="checkbox"/> NO	

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	AM <input type="checkbox"/> PM <input type="checkbox"/>	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	AM <input type="checkbox"/> PM <input type="checkbox"/>	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? <input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
		WERE THEY USED?	<input type="checkbox"/> YES <input type="checkbox"/> NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL (NAME & ADDRESS)	INITIAL TREATMENT NO MEDICAL TREATMENT (0) <input type="checkbox"/> MINOR: BY EMPLOYER (1) <input type="checkbox"/> MINOR CLINIC/HOSP (2) <input type="checkbox"/> EMERGENCY CARE (3) <input type="checkbox"/> HOSPITALIZED > 24 HRS (4) <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) <input type="checkbox"/>
WITNESSES (NAME & PHONE #)		

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER
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Mississippi School Boards Association



**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



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	Oscos 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