NEW CLAIM INFORMATION COVER SHEET

TO:

TPA:	**JT² Integrated Resources**
ADDRESS:	**P.O. Box 8021** **Pleasanton, CA 94588**
EMAIL:	**newclaims@jt2.com**
TELEPHONE #:	**(800) 582-4671**
FAX #:	**(925) 474-0244**

FROM:

RTW DEPARTMENT COORDINATOR:	
TELEPHONE #:	
EMAIL:	

TODAY'S DATE:	# OF PAGES:

URGENT

Please send acknowledgment within 48 hours.

EMPLOYEE'S NAME:	DEPARTMENT:
INCIDENT DATE:	DIVISION:

DOCUMENTS		
ATTACHED	TO FOLLOW	
☐	☐	DWC-1 Employee's Claim for Workers' Compensation Benefits
☐	☐	5020 Employer's Report of Injury or Illness
☐	☐	Employee Incident/Accident Report
☐	☐	Supervisor Incident/Accident Investigation Report
☐	☐	Authorization to Disclose Health Information (HIPAA)
YES	NO	
☐	☐	**Employee is advised to call the Nurse Hotline (Injury Care Direct at 1-877- 247-5431)**

☐ PLEASE CONSIDER FURTHER INVESTIGATION ON THIS CLAIM (IF BOX IS CHECKED)
☑ PLEASE ACKNOWLEDGE RECEIPT OF THIS CLAIM WITHIN 48 HOURS.
☑ PLEASE FORWARD A COPY OF THE 5020 "EMPLOYER'S REPORT OF INJURY OR ILLNESS" TO **NEWCLAIMS@JT2.COM** WITHIN 24 HOURS.

COMMENTS:

CONFIDENTIALITY NOTICE: This message is intended only for the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited, and you are requested to please notify us immediately by telephone, and delete this message forthwith. We truly appreciate your cooperation.

Original: Employee's Workers' Compensation/Medical File
Copy: Claims Examiner, Third Party Administrator

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Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Your employer will then complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. There is a limit on some medical services.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor or medical group. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Different rules apply if your employer is using a Health Care Organization (HCO) or a Medical Provider Network (MPN). A MPN is a selected network of health care providers to provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to be liable for up to $10,000 in treatment until the claim is accepted or rejected.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, for most injuries you will receive temporary disability payments for a limited period of time. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Se adjunta el formulario para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el administrador de reclamos, quien es responsable por el manejo de su reclamo, le notificará sobre su elegibilidad para beneficios.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos. Los beneficios no pueden comenzar hasta, que el administrador de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Hay un límite para ciertos servicios médicos.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico con la responsabilidad total para tratar su lesión o enfermedad. Generalmente, su empleador selecciona al *PTP* que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico o grupo médico previamente designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas differentes que se aplican cuando su empleador usa una Organización de Cuidado Médico (HCO) o una Red de Proveedores Médicos (MPN). Una MPN es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una HCO o una MPN. Hable con su empleador para más información. Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

Dentro de un día después de que Ud. Presente un formulario de reclamo, su empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a la presunta lesión y será responsable por $10,000 en tratamiento hasta que el reclamo sea aceptado o rechazado.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal para la mayoría de las lesions por un period limitado. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos

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be temporary or may be extended depending on the nature of your injury or illness.

Payment for Permanent Disability: If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

Supplemental Job Displacement Benefit (SJDB): If you were injured after 1/1/04 and you have a permanent disability that prevents you from returning to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a nontransferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability.

Death Benefits: If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation (DWC), or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. You may also go to the DWC website at www.dwc.ca.gov.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at **www.californiaspecialist.org**.

por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no pueda trabajar durante más de 14 días.

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atienda, el administrador de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado u otro trabajo podría ser temporal o podría extenderse dependiendo de la índole de su lesión o enfermedad.

Pago por Incapacidad Permanente: Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, su edad, su ocupación y la fecha de la lesión.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. Se lesionó después del 1/1/04 y tiene una incapacidad permanente que le impide regresar al trabajo dentro de 60 días después de que los pagos por incapacidad temporal terminen, y su empleador no ofrece un trabajo modificado o alternativo, es posible que usted reúna los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales basado en su porcentaje de incapacidad permanente.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a los parientes o a las personas que viven en el hogar y que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (El Codigo Laboral sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División Estatal de Compensación de Trabajadores *(Division of Workers' Compensation – DWC)* o puede escuchar información grabada, así como una lista de oficinas locales llamando al **(800) 736-7401**. Ud. también puede consultar con la pagína Web de la DWC en www.dwc.ca.gov.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, ó consulte con la pagína Web en **www.californiaspecialist.org**.

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* _____
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.*
    JT2 INTEGRATED RESOURCES, P.O. BOX 8021, PLEASANTON, CA 94588
15. Insurance Policy Number. *El número de la póliza de Seguro.* SELF INSURED
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/ *Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

6/10 Rev.

Access to Medical Care

Welcome to EIA MPN

Your employer has elected to provide you with the choice of a broad scope of medical services for work-related injuries and illnesses by implementing a Medical Provider Network (MPN), called EIA MPN. EIA MPN delivers quality medical care through your choice of a provider who is part of an exclusive network of healthcare providers, each of whom possess a deep understanding of the California workers' compensation system and the impact their decisions have on you. Your employer has received the approval from the State of California to cover your workers' compensation medical care needs through the EIA MPN. You are automatically covered by the EIA MPN if your date of injury or illness is on or after your employer's MPN implementation date and if you have not properly pre-designated a personal physician prior to your injury or illness.

In the event that you have an injury or illness, you may carry this pamphlet with you to present to your medical service providers for access to care.

This pamphlet is not required to receive medical services.

■ Initial Care

In case of an emergency, you should call 911 or go to the closest emergency room.

In the event that you experience a work-related injury or illness, immediately notify your supervisor and obtain medical authorization from your employer to designate an initial care provider within the network. If you are unable to reach your supervisor or employer, please contact the patient services department at EIA MPN. For non-emergency services, the MPN must ensure that you are provided an appointment for initial treatment within 3 business days of your employer's or MPN receipt of request for treatment within the MPN.

■ Subsequent Care

If you still need treatment following your initial evaluation, you may be treated by a physician of your choice, or the initial physician may refer you to a medically and geographically appropriate specialist within the network who can provide the appropriate treatment for your injury or condition. Your employer is required to provide you with at least three physicians of each specialty expected to treat common injuries experienced by injured employees based on your occupation or industry. These physicians will be available within 30 minutes or 15 miles of your workplace or residence and specialists will be available within 60 minutes or 30 miles of your residence or workplace. For a directory of providers, please visit www.eiampn.csac-eia.org or call EIA MPN Patient Services.

■ Emergency Care

In an emergency, defined as a medical condition starting with the sudden onset of severe symptoms that without immediate medical attention could place your health in serious jeopardy, go to the nearest healthcare provider regardless of whether they are a EIA MPN participant. If your injury is work-related, advise your emergency care provider to contact EIA MPN to arrange for a transfer of your care to a EIA MPN provider at the medically appropriate time.

■ Hospital and Specialty Care

Your primary treating provider in the EIA MPN can make all of the necessary arrangements and referrals for specialists, inpatient hospital, outpatient surgery center services, and ancillary care services.

■ Choosing a Treating Physician

If you still require treatment after your initial evaluation with your employer's designated provider, you may access the EIA MPN Directory and select an appropriate physician of your choice who can provide the necessary treatment for your condition or illness. For assistance determining physician options, please contact the Medical Access Assistant in the EIA MPN Patient Services Department or discuss your options with your initial care provider.

■ Scheduling Appointments

If you are having difficulty scheduling an appointment with your initial provider or subsequent provider, please contact the Medical Access Assistant EIA MPN Patient Services Department or your Claims Examiner.

■ Changing Primary Treating Physician

If you find it necessary to change your treating physician and it is determined that you require ongoing medical care for your injury or illness, you may select a new physician from the EIA MPN Directory and schedule an appointment. Once your appointment is scheduled, immediately contact EIA MPN Patient Services who will then coordinate the transfer of your medical records to your new provider.

■ Obtaining a Specialist Referral

As long as you continue to require medical treatment for your injury or illness, there are alternatives for obtaining a referral to a specialist:

1. Your primary treating provider in the EIA MPN can make all of the necessary arrangements for referrals to a specialist. This referral will be made within the network or outside of the network if needed.
2. You may select an appropriate specialist by accessing the EIA MPN Directory.
3. You may contact the Medical Access Assistants in the EIA MPN Patient Services who can help coordinate necessary arrangements.

If your primary treating provider makes a referral to a type of specialist not included in the network, you may select a specialist from outside the network.

For non-emergency specialist services, the MPN must ensure that you are provided an appointment within 20 business days of your employer's or MPN receipt of a referral to a specialist within the MPN.

■ Continuity of Care

What if I am being treated by a EIA MPN doctor and the doctor leaves EIA MPN?

Your employer has a written "**Continuity of Care**" Policy that may allow you to continue treatment with your doctor if your doctor is no longer actively participating in EIA MPN.

If you are being treated for a work-related injury in the EIA MPN and your doctor no longer has a contract with EIA MPN, your doctor may be allowed to continue to treat you if your injury or illness meets one of the following conditions:

- **(Acute)** A medical condition that includes a sudden onset of symptoms that require prompt care and has a duration of less than 90 days.
- **(Serious or Chronic)** Your injury or illness is one that is serious and continues for at least 90 days without full cure or worsens and requires ongoing treatment. You may be allowed to be treated by your current treating doctor for up to one year, until a safe transfer of care can be made.
- **(Terminal)** You have an incurable illness or irreversible condition that is likely to cause death within one year or less.
- **(Pending Surgery)** You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN contract termination date.

If any of the above conditions exist, EIA MPN may require your doctor to agree in writing to the same terms he or she agreed to when he or she was a provider in the EIA MPN. If the doctor does not, he or she may not be able to continue to treat you.

If the contract with your doctor was terminated or not renewed by EIA MPN for reasons relating to medical disciplinary cause or reason, fraud or criminal activity, you will not be allowed to complete treatment with that doctor. For a complete copy of the Continuity of Care policy in English or Spanish, please visit www.eiampn.csac-eia.org or call EIA MPN Patient Services.

■ Transfer of Ongoing Care

What if you are already being treated for a work-related injury before the EIA MPN begins?

Your employer has a "**Transfer of Care**" policy which describes what will happen if you are currently treating for a work-related injury with a physician who is not a member of the EIA MPN.

If your current treating doctor is a member of EIA MPN, then you may continue to treat with this doctor and your treatment will be under EIAMPN.

If your current treating physician is not a participating physician within EIA MPN and you have not yet been transferred into the MPN, your physician can make referrals to providers within or outside the MPN. Your current doctor may be allowed to become a member of EIA MPN.

You will not be transferred to a doctor in EIA MPN if your injury or illness meets any of the following conditions:

- **(Acute)** The treatment for your injury or illness will be completed in less than 90 days.
- **(Serious or Chronic)** Your injury or illness is one that is serious and continues without full cure or worsens over 90 days. You may be allowed to be treated by your current treating doctor for up to one year from the date of receipt of the notification that you have a serious chronic condition.
- **(Terminal)** You have an incurable illness or irreversible condition that is likely to cause death within one year or less. Treatment will be provided for the duration of the terminal illness.
- **(Pending Surgery)** You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN effective date.
- For a complete copy of the Transfer of Care policy in English or Spanish, please visit www.WellComp.com or call WellComp Patient Services.

■ Care Disputes

Notice of determination, from the employer or claims examiner, shall be sent to the covered employee's address and a copy of the letter shall be sent to the covered employee's primary treating physician. The notification shall be written in English and Spanish and use layperson's terms to the maximum extent possible.

If EIA MPN is going to transfer your care and you disagree, you may ask your treating doctor for a report that addresses whether you are in one of the categories listed above. Your treating physician shall provide a report to you within twenty calendar days of the request. If the treating physician fails to issue the report, then you will be required to select a new provider from within the MPN.

If either EIA MPN or you do not agree with your treating doctor's report, this dispute will be resolved according to Labor Code Section 4062. You must notify EIA MPN Patient Services Department, if you disagree with this report.

If your treating doctor agrees that your condition does not meet one of those listed above, the transfer of care will go forward while you continue to disagree with the decision.

If your treating doctor believes that your condition does meet one of those listed above, you may continue to treat with him or her until the dispute is resolved. For a complete copy of the Transfer of Care policy, please visit www.eiampn.csac-eia.org or call EIA MPN Patient Services.

Second Opinion, Third Opinion and Independent Medical Review Process:

If you disagree with your doctor or do not like your doctor for any reason, you may always choose another doctor in the MPN.

■ Obtaining Second and Third Opinions

If you disagree with the diagnosis or treatment plan determined by your treating physician or your second opinion physician, and would like a second or third opinion, you must take the following steps:

- ✓ Notify your claims examiner who will provide you with a regional area listing of physicians and/or specialists within the EIA MPN who have the recognized expertise to evaluate or treat your injury or condition.
- ✓ Select a physician or specialist from the list.
- ✓ Within 60 days of receiving the list, schedule an appointment with your selected physician or specialist from the list provided by your claims examiner. Should you fail to schedule an appointment within 60 days, your right to seek another opinion will be waived.
- ✓ Inform your claims examiner of your selection and the appointment date so that we can ensure your medical records can be forwarded in advance of your appointment date. You may also request a copy of your medical records.
- ✓ You will be provided information and a request form regarding the Independent Medical Review (IMR) process at the time you select a third opinion physician. Information about the IMR process can be found in the MPN Employee Handbook.

If the second opinion doctor feels that your injury is outside of the type of injury he or she normally treats, the doctor's office will notify your employer or insurer. You will get another list of MPN doctors or specialists so you can make another selection.

If the 2nd/3rd opinion doctor agrees with your need for a treatment or test, you may be allowed to receive that recommended treatment or test from a provider inside or outside the MPN, including the 2nd or 3rd opinion physician.

■ Obtaining an Independent Medical Review (IMR)

If you disagree with the diagnosis or treatment plan determined by the third opinion physician, you may file the completed Independent Medical Review Application form with the Administrative Director of the Division of Workers' Compensation. You may contact your claims examiner or the EIA MPN Patient Services Department for information about the Independent Medical Review process and the form to request an Independent Medical Review.

If the second opinion, third opinion or IMR agrees with your treating doctor, you will need to continue to receive medical treatment with a network physician if MPN contains a physician who can provide the recommended treatment. If the IMR does not agree with your treating network physician, you will be allowed to receive that medical treatment from a provider either inside or outside of the EIA MPN.

Any physician chosen outside of the WellComp Network must be within reasonable geographic area. The treatment or diagnostic test is limited to the recommendation of the MPN/ IMR.

■ Treatment Outside of the Geographic Area

EIAMPN has providers throughout California. If a situation arises which takes you out of the coverage area, such as temporary work, travel for work, or living temporarily or permanently outside the MPN geographic service area, please contact the EIA MPN Patient Services Department, your claims examiner, or your primary treating provider, and they will provide you with a selection of at least 3 approved out-of-network providers from whom you can obtain treatment or get second and third opinions from the referred selection of physicians.

Covered Medical Services:

The following is a summary of Workers' Compensation medical services that are available to employees covered by the EIA MPN.

Primary treating and specialty services including consultations and referrals

Examples of primary treating or specialty providers include: general medical practitioners, chiropractors, dentists, orthopedists, surgeons, psychologists, internists, psychiatrists, cardiologists, neurologists.

Inpatient Hospital and Outpatient Surgery Center services

Examples of inpatient hospital and outpatient surgery center providers include: acute hospital services, general nursing care, operating room and related facilities, intensive care unit and services, diagnostic lab or x-ray services, necessary therapies.

Ancillary Care services

Examples of ancillary care providers include: diagnostic lab or x-ray services, physical medicine, occupational therapy, medical and surgical equipment, counseling, nursing, medically appropriate home care, medication.

Emergency services including outpatient and out-of area emergency care

EIA MPN
MEDICAL PROVIDER NETWORK

EIA MPN Provider Directory

For more information about the EIA MPN including access to a roster of all treating physicians in the EIA MPN, go to www.eiampn.csac-eia.org where you can search by medical specialty, zip code, physician or provider group. For website assistance or to access a hard copy of the regional area listing and/ or an electronic copy of the complete EIA MPN directory, please contact EIA MPN (your employer's designated medical provider network administrator):

EIA MPN Information

For questions about the use of EIA's MPN or complaints
The EIA MPN contact is: Gale Chmidling,
MPN Manager (800)544-8150

EIA has individuals available to answer questions, provide website assistance, and generate provider listings. Medical Access Assistants are available to assist with finding an EIA MPN physicians of your choice, including scheduling and confirming physician appointments. Assistants are available 7am to 8pm Pacific Standard Time, Monday through Saturday at the contact information below:

EIA MPN
Patient Services Department
P.O. Box 59914
Riverside, CA 92517
Toll Free (800) 544-8150
fax: (888) 620-6921 or
e-mail: info@eiampn.csac-eia.org

Rev 12/14

EIA MPN
MEDICAL PROVIDER NETWORK

Employee Notification

This pamphlet contains important information on accessing the EIA Medical Provider Network:

- ✓ Find out if you are covered
- ✓ Access medical care
- ✓ Learn about continuity of care
- ✓ Chooseyour own physician
- ✓ Transfer into the Network
- ✓ Contact EIA MPN

MPN Identification Number: ____

This pamphlet is available in Spanish. For a free copy, please contact EIA MPN.

Este folleto esta disponible en el Español. Para una copia gratis, favor de llamar a EIA MPN

Accesibilidad al Cuidado Médico

Bienvenidos a EIA MPN

Su empleador ha elegido proveerle a usted con una amplia selección de servicios médicos en casos de lesiones y enfermedades relacionadas con su trabajo, y para ello ha establecido una Red de Proveedores Médicos (MPN por sus siglas en inglés), llamada EIA MPN. EIA MPN suministra cuidado médico de calidad a través de su elección de un proveedor médico que esta afiliado a una red exclusiva de proveedores de asistencia sanitaria, donde cada uno posee un profundo entendimiento del sistema del Seguro de Indemnización por Accidentes de Trabajo del estado de California y el impacto que sus decisiones tienen en su persona. Su empleador ha recibido aprobación del Estado de California para cubrir sus necesidades de cuidado médico relacionadas con el Seguro de Indemnización por Accidentes de Trabajo a través de la Red EIA MPN. Usted está protegido automáticamente por la Red EIA MPN si la fecha de su lesión o enfermedad es en o después de la fecha del establecimiento de EIA MPN por parte de su empleador, y si usted no ha pre-designado un doctor personal antes de su lesión o enfermedad.

En caso de que usted tenga una herida o la enfermedad, usted puede llevar este folleto con usted para presentar a su abastecedor de servicio médico para el acceso preocuparse.

No se requiere que este folleto reciba servicios médicos.

Cuidado Inicial

En caso de emergencia usted debe llamar al 911 o ir a la sala de emergencia más cercana.

En caso de que sufra una lesión o enfermedad relacionada con su trabajo, notifique inmediatamente a su supervisor y obtenga autorización médica de su empleador para designar un proveedor médico dentro de la Red, para el cuidado inicial. Si usted no puede comunicarse con su supervisor o empleador, por favor comuníquese con el Departamento del Servicio al Paciente de EIA MPN. Para servicios que no sean de emergencia, el MPN tendra que asegurar que usted es proveido(a) una cita o tratamiento inicial dentro de 3 dias de negocio de que su empleador o el MPN a recibido un pedido de tratamiento dentro del MPN.

Cuidado Subsiguiente

Si usted aún necesita atención después de la evaluación inicial, usted puede ser atendido por un doctor de su agrado, o el doctor inicial puede referirle a usted a un especialista médicamente y geográficamente apropiado dentro de la Red, el cual puede proveer el tratamiento adecuado para su lesión o condición. Su empleador es requerido a proveerle de por lo menos 3 medicos de cada especialidad esperada para tartar leciones experimentadas por empleados lecionados basado en su ocupacion o industria. Estos medicos estaran disponibles dentro de 30 minutos o 15 millas de su lugar de trabajo o residencia y especialistas estaran disponibles dentro de 60 minutos o 30 millas de su lugar de trabajo. Para conseguir un directorio de los proveedores médicos, por favor visite www.eiampn.csac-eia.org o llame al Servicio al Paciente de EIA MPN.

Cuidado de Emergencia

En una emergencia, definida como una condición médica que se manifiesta de forma imprevista, con síntomas severos, los cuales sin atención médica inmediata pueden poner en sumo riesgo su salud, vaya al proveedor de atención médica más cercano sin importar si participan en la Red de EIA MPN. Si su lesión está relacionada con su trabajo, pídale al proveedor del cuidado de emergencia, que se comunique con EIA MPN para preparar la transferencia de su atención médica, a un proveedor de EIA MPN cuando sea el tiempo médicamente adecuado para hacerlo.

Cuidado Especializado y de Hospital

El proveedor principal de la Red EIA MPN de su tratamiento, puede hacer todos los arreglos y referencias necesarias para los , especialistas hospitales, centro de cirugía de servicio ambulatorio y servicios de cuidados auxiliares.

Elección de Doctor para el Tratamiento

Si aún necesita tratamiento después de su evaluación inicial con el proveedor designado de su empleador, puede acceder al directorio WellComp y seleccione a un apropiado médico de su elección que puede proporcionar el tratamiento necesario para su condición o enfermedad. Para asistencia en obtener opciones de medicos, favor de contactar al Asistente de Acceso Medico en el Departamento de Servicios al Paciente de WellComp o discutir las opciones con el medico inicial.

Cambiando el Doctor Principal de su Tratamiento

Si usted está teniendo dificultades para programar una cita con su medico inicial o posterior, favor de comunicarse con el Asistente de Acceso Médico en el Departamento de Servicios al Paciente de WellComp o con el ajustador de reclamos que maneja su caso.

Reservación de Citas

Si usted tiene problemas haciendo sus reservaciones de citas con el proveedor inicial o el proveedor subsiguiente, por favor comunicarse con el Departamento de Servicio al Paciente de EIA MPN.

Obteniendo una Recomendación a un Especialista

Siempre y cuando usted continúe necesitando cuidado médico para su lesión o enfermedad, hay varias alternativas para obtener una recomendación a un especialista:

1. Su proveedor principal en la Red de EIA MPN puede hacer todos los trámites necesarios para la recomendación a un especialista. Esta recomendación será echa dentro de la Red y si es necesario fuera de la Red.
2. Usted puede seleccionar un especialista adecuado usando el Directorio de EIA MPN.
3. Usted puede comunicarse con el Asistente de Acceso Medico de EIA MPN quien le puede ayudar a coordinar arreglos necesarios.

Si su proveedor de tratamiento primario hace un referido a una clase de especialista que no esta incluido dentro la red, usted puede seleccionar un especialista fuera de la red.

Para servicios que no sean de emergencia, el MPN tendra que asegurar que usted es proveido(a) una cita dentro de 20 dias de negocio de que su empleador o el MPN a recibido un referido a un especialista dentro del MPN.

Continuidad de su Cuidado

¿Que pasa si estoy siendo tratado por un doctor de EIA MPN y el doctor deja a EIA MPN?

Su empleador ha suscrito una póliza de "Continuidad de Cuidado" que puede permitirle a usted continuar el tratamiento con su doctor, si su doctor no está actualmente participando en EIA MPN.

Si usted está siendo tratado dentro de la Red EIA MPN por una lesión relacionada con su trabajo y su doctor deja de tener un contrato con EIA MPN, su doctor puede continuar tratándolo siempre y cuando su lesión o enfermedad satisface una de las siguientes condiciones:

- **(Aguda)** Condición médica que incluye síntomas que se manifiestan de forma imprevista y que requieren pronta atención médica, y tiene duracion menos de 90 dias.
- **(Seria o Crónica)** Su herida o enfermedad son el que que es serio y sigue durante al menos 90 días sin la cura llena o empeora y requiere el tratamiento en curso. Se le puede permitir que siga siendo tratado por el doctor que actualmente lo esta tratando por un período de hasta un año, hasta que una transferencia de cuidado pueda ser efectuada de una manera sana y salva.
- **(Terminal)** Usted tiene una enfermedad incurable o condición irreversible que probablemente cause la muerte dentro de un año o menos.
- **(Cirugía Pendiente)** Usted ya tiene una cirugía u otro procedimiento autorizado por su empleador o seguro de salud y el cual ocurrirá dentro de los 180 días de la fecha efectiva de la Red de Proveedores Médicos (MPN por sus siglas en inglés).

Si cualquiera de las condiciones antes mencionadas existe, EIA MPN puede requerir que su doctor acepte por escrito los mismos términos que el había aceptado cuando era un proveedor del Red de EIA MPN. Si el doctor no está de acuerdo o no acepta los términos, no podría continuar tratándolo.

Si el contrato con su doctor fue clausurado o no fue renovado por EIA MPN por razones relacionadas con causas de disciplina médica, fraude o actividad criminal, no le será permitido completar el tratamiento con ese doctor. Para obtener una copia completa de la póliza de Continuidad de Cuidado en inglés o en español, por favor visite www.eiampn.csac-eia.org o llame a servicios al paciente de EIA MPN.

Transferencia del Cuidado Actual y Corriente

¿Qué pasa si usted ya está siendo tratado por una lesión relacionada con su trabajo, antes de comenzar el programa Red de EIA MPN?

Su empleador tiene una póliza de "Transferencia de Cuidado" que describe lo que pasará si usted esta actualmente siendo tratado por una lesión relacionada con su trabajo, por un doctor que no es miembro de la Red de EIA MPN.

Si su doctor actual del tratamiento es un miembro participante de EIA MPN, entonces usted puede continuar el tratamiento con su doctor y su tratamiento se hará bajo la Red de EIA MPN. Se le puede permitir ser miembro de EIA MPN a su doctor actual.

Si su médico tratante actual no es un médico participante dentro de EIA MPN, y si aún no ha sido transferido a la red de proveedores medicos, su médico puede hacer remisiones a prestadores dentro o fuera de la red de proveedores medicos. Se le puede permitir a su medico actual convertirse en un miembro de EIA MPN. Usted no será transferido a un doctor de EIA MPN si su lesión o enfermedad satisface cualquiera de las siguientes condiciones:

- **(Aguda)** El tratamiento de su lesión o enfermedad será completado en menos de 90 días.
- **(Seria o Crónica)** Su lesión o enfermedad es seria y continuará por mas de 90 días sin cura completa o empeorando y requiere tratamiento continuo. Se le puede permitir que siga siendo tratado por el doctor que actualmente lo esta tratando por un período de hasta un año de la fecha de notificacion que usted tiene una condicion seria o cronica.
- **(Terminal)** Usted tiene una enfermedad incurable o condición irreversible que probablemente cause la muerte dentro de un año o menos. Tratamiento medico sera proporcionado por la duracion de la enfermedad terminal.
- **(Cirugía Pendiente)** Usted ya tiene una cirugía o procedimiento autorizado por su empleador o seguro de salud y el cual ocurrirá dentro de los 180 días de la fecha efectiva de la Red de Proveedores Médicos (MPN por sus siglas en inglés).
- Para obtener una copia completa de la poliza de Transferencia de Cuidado en español o en ingles, por favor visite www.eiampn.csac-eia.org o llame a servicios al paciente de EIA MPN.

Disputas de Cuidado

Anuncio de la determinación, proveniente del empleador, o del ajustador encargado del caso, debera ser enviada a la dirección del empleado y una copia de la carta deberá ser enviada al medico principal del empleado cubierto. La notificación será escrita en inglés y español y los términos del lego de uso en el mayor grado possible.

Si EIA MPN va a transferir su cuidado médico y usted no está de acuerdo, usted puede pedirle al doctor que lo está tratando actualmente, un informe o parte médico alegando que su condición pertenece o está dentro de una de las condiciones antes mencionadas. Su doctor que lo esta tratando actualmente si le proveera un informe dentro de veinte dias del calendario de la fecha de solicitacion. Si su doctor que lo esta tratando actualmente no logra emitir el informe, entonces usted sera requerido a selecionar un nuevo proveedor dentro el MPN.

Si EIA MPN o usted no está de acuerdo con el informe del doctor que lo está tratando, esta disputa será resuelta de acuerdo a la Sección 4062 del Código del Trabajo. Usted tiene que notificar al Departamento del Servicio al Paciente de EIA MPN, si usted no está de acuerdo con el informe o parte médico.

Si el doctor que lo está tratando está de acuerdo de que su condición no pertenece o no está dentro de las condiciones antes mencionadas, se continuará con la transferencia de su cuidado médico, aún cuando usted no está de acuerdo con la decisión.

Si su doctor cree que su condición satisface una de las condiciones antes mencionadas, usted puede continuar el tratamiento con ese doctor hasta que la disputa sea resuelta. Para obtener una copia completa de la póliza de Transferencia de Cuidado, por favor visite www.eiampn.csac-eia.org o llame al Servicio al Paciente de EIA MPN.

Proceso para Segunda Opinión, Tercera Opinión y Examen Médico Independiente:

Si usted no está de acuerdo con su doctor o no le gusta su doctor sea cual sea la razón, usted siempre puede elegir otro doctor en el MPN (Red de Proveedores).

■ Obteniendo Segunda y Tercera Opiniones

Si usted no está de acuerdo con el diagnóstico o con el plan de tratamiento de su doctor actual o con el doctor de la segunda opinión, y quisiera una segunda o tercera opinión, usted debe de tomar los siguientes pasos:

- ✓ Notificar al Administrador(a) de su reclamo a quien le proveerá una lista de doctores y/o especialistas en el area regional dentro de la Red de EIA MPN, quienes tienen pericia reconocida para evaluar o tratar su lesión o condición.
- ✓ Elija de la lista un doctor o especialista.
- ✓ Dentro de los 60 días de recibir la lista, reserve una cita con el doctor o especialista seleccionado de la lista proporcionada a tráves del por Administrador(a) de su reclamo. Si, dentro de los 60 días, decide usted en no confirmar cita, su derecho en buscar otra opinion puede ser renunciado.
- ✓ Informe al Administador(a) de su reclamo de su elección, y de la fecha de su cita, para así asegurarnos de que sus archivos médicos se pueden enviar antes de la fecha de su cita. Usted tambien puede pedir una copia de sus archivos medicos.
- ✓ Usted sera proveido(a) con informacion y un impreso de pedido referente al proceso de Examinacion de Medico Independiente (IMR) en el momento que usted selecciona un medico de tercera opinion. Informacion del proceso del IMR se puede encontrar en el Manual del MPN para el Empleado.

Si el segundo/tercer doctor de opinión siente que su herida es fuera del tipo de herida él o ella normalmente trata, el consultorio del doctor notificará a su patrón o asegurador. Usted conseguirá otra lista de doctores MPN o especialistas entonces usted puede hacer otra selección.

Si la 2da/3ra opinion médico está de acuerdo con su necesidad de un tratamiento o algun examen, se le permitira obtener ese tratamiento o examen con un proveedor que este dentro o fuera de la red de proveedors medicos, incluyendo el medico quien proporciono la 2da/3ra opinion.

■ Obteniendo un Examen Médico Independiente (IMR por sus siglas en inglés)

Si usted no esta de acuerdo con el diagnostico o plan de tratamiento decidido por el medico de la tercera opinion, usted podria completer y presentar el impreso de la Aplicacion para Examinacion de MPN Medico Independiente con el Director Administrativo de la Division de Indemnizacion de Trabajadores. Usted puede ponerse en contacto con el Departamento de Servicios para el Paciente de EIA MPN para informacion sobre la Examinacion de Medico Independiente y el impreso para pedir una Examinacion de Medico Independiente.

Si la segunda opinión, tercera opinión o la revision medica independiente, coincide con el medico que le esta tratando, y la red de proveedores medicos contiene un medico que pueda proporcionar el tratamiento recomendado, usted tendra que continuar su tratamiento con un medico dentro de la red de proveedores medicos. Si la revision medica independiente no está de acuerdo con su médico tratante de la red, se permitirá recibir ese tratamiento médico de un proveedor dentro o fuera de la red de EIA MPN.
Cualquier médico seleccionado fuera de la red de proveedores medicos de EIA MPN debe estar a una distancia geográfica razonable. El tratamiento o examen de diagnóstico esta limitado a la recomendación provista por el medico dentro de la red de proveedores medicos o por la revision medica independiente.

■ Tratamiento Fuera del Área Geográfica

EIA MPN tiene proveedores por toda California. Si llega alguna situacion que podria llevarlo fuera del area de cubertura, tales como trabajo temporal, viaje relacionado al trabajo, o vivir temporalmente o constantemenconsultaciones y recomendaciones te fuera del area de servicios geograficos del MPN, porfavor pongase en contacto con el Departamento de Servicios para Pacientes de EIA MPN, su examinador de reclamos, su proveedor primario de tratamiento, y ellos le proveeran con una seleccion de por lo menos 3 proveedores aprovados fuera de la red de los que usted pueda obtener tratamiento o recibir segunda o tercera opinions de la seleccion de medicos referidos.

Servicios Médicos Proveídos:

A continuación es un resumen de los servicios médicos del Seguro de Indemnización por Accidentes de Trabajo disponibles para usted por la Red de EIA MPN.

Tratamiento principal o primario y servicios especiales incluyendo las consultaciones y recomendaciones

Ejemplos de proveedores de tratamientos primarios o proveedores de especialización incluyen: doctores de medicina general, quiroprácticos, dentistas, ortopedistas, cirujanos, psicólogos, psiquiatras, cardiólogos, neurólogos.

Servicios de Hospital, y Centros de Cirugía Ambulatoria

Ejemplos de servicios de proveedores de servicios de hospital, y centros de cirugía ambulatoria incluyen: servicio agudo de hospital, cuidado general de enfermera, salas de operaciones y facilidades relacionadas, unidad de cuidado intensivo y sus servicios, laboratorios para diagnósticos o servicio de rayos-x y los tratamientos de terapias necesarias.

Servicios de Cuidado Complementarios

Ejemplos de proveedores de servicios de cuidado complementarios incluyen: laboratorios para diagnósticos o servicio de rayos-x, medicina física, terapia de ocupación, equipos médicos y de cirugía, consejeros, enfermeras, cuidado médico apropiado en casa, medicación.

Servicios de Emergencia incluye el servicio ambulatorio y servicio fuera del área de la Red.

EIA MPN
MEDICAL PROVIDER NETWORK

Directorio de Proveedores de EIA MPN

Para obtener más información acerca de la red de proveedores medicos, incluyendo el acceso a una lista de todos los médicos en la red, vaya a www.eiampn.csac-eia.org donde se puede buscar por especialidad médica, el código postal, grupo médico o proveedor. Para asistencia atraves del internet o para optener acceso a una copia impresa de la lista de proveedores por zona regional y/o una copia electrónica del directorio completo de EIA MPN, favor de contactarse con WellComp (quien fue asignado por su empleador para administrar la red de proveedores medicos):

Informacion de EIA MPN

Para preguntas sobre el uso de la red de proveedores medicos o para denuncias, la persona a contactar es: Gale Chmidling, MPN Manager (800) 544-8150.

WellComp tiene personas disponibles para responder a sus preguntas, proporcionar asistencia con el sitio web y para generar listas de proveedores. Asistentes están disponibles para ayudar a encontrar un médico de su elección dentro de la red de proveedores, incluyendo programación y confirmacion de las citas. Los asistentes están disponibles de 7am a 8pm hora del Pacífico, de lunes a sábado. Información de contacto aparece a continuacion:

EIA MPN
Departamento de Servicios al Paciente
P.O. Box 59914
Riverside, CA 92517
Gratis al (800) 544-8150
fax: (888) 620-6921 o
e-mail: info@eiampn.csac-eia.org

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EIA MPN
MEDICAL PROVIDER NETWORK

Notificación al Empleado

Este folleto contiene información importante para el acceso en la Red de Proveedores Médicos EIA MPN.

- ✓ Entérese si está protegido
- ✓ Acceso a cuidado médico
- ✓ Aprenda acerca de la continuidad de su cuidado
- ✓ Seleccione su propio doctor
- ✓ Transferencia dentro de la Red de EIA MPN
- ✓ Comunicarse con EIA MPN

Número de identificación del MPN: ☐

Este folleto está disponible en Ingles. Para una copia gratis, por favor llame la Red de Proveedores Médicos EIA MPN.

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible). Mail two copies to:

JT² INTEGRATED RESOURCES
P.O. Box 8021
Pleasanton, CA 94588
(800) 582-4671

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony

California law requires employers to report within **five days** of knowledge every occupational injury or illness, which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME: City of Oakland
1a. Policy Number:
2. MAILING ADDRESS (Number and Street, City, Zip): 150 Frank Ogawa Plaza, 2nd Floor, Oakland, CA 94612
2a. Phone Number:
3. LOCATION IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, Zip):
3a. Location Code:
4. NATURE OF BUSINESS; e.g. Painting contractor, wholesale grocer, sawmill, hotel, etc.: Municipality
5. State Unemployment Insurance Acct. #:
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☒ City ☐ School Dist ☐ Other Government - Specify _____

INJURY OR ILLNESS

7. DATE OF INJURY/ONSET OF ILLNESS (mm/dd/yy):
8. TIME INJURY/ILLNESS OCCURRED: ____ A.M. ____ P.M.
9. TIME EMPLOYEE BEGAN WORK: ____ A.M. ____ P.M.
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy):
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO
12. DATE LAST WORKED (mm/dd/yy):
13. DATE RETURNED TO WORK (mm/dd/yy):
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAY'S WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO
16. SALARY BEING CONTINUED? ☐ YES ☐ NO
17. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY (mm/dd/yy):
18. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy):
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g. second degree burns on right arm, tendonitis on left elbow, lead poisoning.
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip):
20a. COUNTY:
21. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping Department, Machine Shop.
23. Other workers injured/ill in this event? ☐ YES ☐ NO
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene welding torch, farm tractor, scaffold.
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld and burned right hand. USE SEPARATE SHEET IF NECESSARY.
27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip):
27a. PHONE NUMBER:
28. HOSPITALIZED AS INPATIENT OVERNIGHT: ☐ NO ☐ YES If yes then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip):
28a. PHONE NUMBER:
29. EMPLOYEE TREATED IN EMERGENCY ROOM? ☐ YES ☐ NO

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29(b)(6)-(10) & 14300.35(b)(2)(E)2.

Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2.*

EMPLOYEE

30. EMPLOYEE NAME:
31. SOCIAL SECURITY NUMBER:
32. DATE OF BIRTH (mm/dd/yy):
33. HOME ADDRESS (Number, Street, City, Zip):
33a. PHONE NUMBER:
34. SEX ☐ MALE ☐ FEMALE
35. OCCUPATION (Regular job title - NO initials, abbreviations or numbers):
36. DATE OF HIRE (mm/dd/yy):
37. EMPLOYEE USUALLY WORKS _____ hours per day _____ days per week _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED?
38. GROSS WAGES/SALARY: $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ YES ☐ NO

PLEASE DO NOT USE THIS COLUMN
CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

Completed by (type or print)

Signature & Title

Date (mm/dd/yy)

*Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim, and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY

UPDATED 4/3/2014

CITY OF OAKLAND: WORKERS' COMPENSATION MANAGEMENT PROGRAM
DEPARTMENT WORKERS' COMPENSATION COORDINATOR PROCEDURES

SUPERVISOR INCIDENT/ACCIDENT INVESTIGATION REPORT

EMPLOYEE:	JOB TITLE:
MAILING ADDRESS:	DEPARTMENT:
	DIVISION:

DATE OF INJURY:	TIME OF EVENT:	LOCATION OF EVENT:
DATE REPORTED:	TIME BEGAN WORK:	INJURY REPORTED TO:

WHAT WAS THE EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED?

HOW DID THE INCIDENT OCCUR?

WHAT BODY PART(S) WAS(WERE) AFFECTED?

WHAT OBJECT/SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?

WITNESS (NAME & ADDRESS/DEPARTMENT):

DO YOU BELIEVE THIS INCIDENT SHOULD BE INVESTIGATED BY THE THIRD PARTY ADMINISTRATOR? ☐ YES ☐ NO

CHECK ANY THAT APPLY:
- ☐ EMPLOYEE WAS NOT WORKING ON DATE OF ALLEGED INCIDENT
- ☐ EMPLOYEE WAS NOT ON CITY BUSINESS WHEN INJURED
- ☐ INJURY/ILLNESS DOES NOT APPEAR TO BE WORK-RELATED
- ☐ EMPLOYEE DID NOT REPORT INCIDENT UNTIL:

MEDICAL TREATMENT	☐ **CHECK BOX IF EMPLOYEE DECLINED MEDICAL TREATMENT**
NAME OF PHYSICIAN:	EMPLOYEE REFERRED TO CLINIC/PHYSICIAN? ☐ YES ☐ NO
	EMPLOYEE TREATED IN EMERGENCY ROOM? ☐ YES ☐ NO
NAME OF CLINIC:	EMPLOYEE HOSPITALIZED OVERNIGHT? ☐ YES ☐ NO
	IF EMPLOYEE DIED, DATE OF DEATH:
ADDRESS:	

UNSAFE ACT (IF ANY)		**PREVENTIVE ACTION(S) TO BE TAKEN**
☐ IMPROPER BODY POSITIONING	☐ UNSAFE USE OF EQUIPMENT	☐ PROVIDE ADDITIONAL TRAINING
☐ HURRIED OR DISTRACTED WORK	☐ IMPROPER LIFTING TECHNIQUE	☐ DISCIPLINE EMPLOYEE
☐ UNSAFE WORK METHOD	☐ OTHER:	☐ MODIFY/DISCONTINUE WORK PRACTICE
☐ FAILURE TO USE PERSONAL PROTECTIVE EQUIP. Specify (goggle, respirator, safety shoes, etc.):		☐ SUPPLY EQUIPMENT:
		☐ OTHER:

UNSAFE CONDITION (IF ANY)		**PREVENTIVE ACTION(S) TO BE TAKEN**
☐ DEFECTIVE EQUIPMENT	☐ IMPROPER DRESS OR APPAREL	☐ ELIMINATE CONDITION
☐ UNGUARDED EQUIPMENT	☐ IMPROPER LIGHTING	☐ REPAIR CONDITION
☐ TRIP/SLIP HAZARD ON FLOOR	☐ DISTRACTION	☐ REPORT CONDITION TO:
☐ UNSAFE ARRANGEMENT OF ITEMS	☐ FUMES	
☐ OTHER:		☐ OTHER:

COMPLETED BY:		TITLE:
SIGNATURE:	DATE:	TELEPHONE:

If a work-connected fatality or hospitalization occurs, contact the Risk Management Division Safety & Loss Control Manager immediately at (510) 238-7165. The State of California requires every Employer to report such incidents immediately (within 8 hours) by telephone or in person to the nearest District Office of the division of Occupational Safety and Health. *Reference: General Industry Safety Orders Section 342 Reporting Work-Connected Fatalities and Serious Injuries*

Initial Distribution: **To Department Workers' Compensation Coordinator in Initial Injury Packet Envelope**
DWCC: Keep original and send copies to Third Party Administrator & Risk Management Division Safety & Loss Control Manager

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CITY OF OAKLAND: WORKERS' COMPENSATION MANAGEMENT PROGRAM
DEPARTMENT WORKERS' COMPENSATION COORDINATOR PROCEDURES

EMPLOYEE INCIDENT/ACCIDENT REPORT

EMPLOYEE NAME: Gender: ☐M ☐F	JOB TITLE:	
HOME ADDRESS:	DEPARTMENT:	
	DIVISION:	
HOME TELEPHONE:	SUPERVISOR:	
DATE OF BIRTH:	DATE OF HIRE:	☐FULL TIME ☐PART TIME

INJURY DATE:	TIME:	LOCATION:
DATE REPORTED:	INJURY REPORTED TO (Name & Position):	

NATURE OF INJURY (e.g., puncture, strain, cut, fracture, burn, etc.):

BODY PART INJURED (e.g., right wrist, left knee, head, lower back, etc.):

INJURY SOURCE (e.g., wet floor, lawn mower, keyboard, etc.):

HOW INJURY OCCURRED (struck by ..., fell from ..., exposed to ..., etc.):

DESCRIBE ANY PREVIOUS CONDITIONS/INJURIES TO BODY PART CURRENTLY INJURED:

EMPLOYEE'S STATEMENT OF WHAT OCCURRED (Include as much detail as possible such as activity being performed, objects carried, equipment used, hazardous conditions, etc.):

WHO WITNESSED THE INCIDENT?

SHARPS INJURY: A sharps injury may include, but is not limited to, cuts, abrasions or needle sticks. If applicable, please provide the following information.

SHARP TYPE: (needle, scalpel, scissors, blade, broken glass, etc.)	SHARP BRAND:
TASK AT TIME OF INJURY:	
ENGINEERING/SAFETY CONTROLS IN USE AT TIME OF INJURY:	DID INJURY OCCUR ☐BEFORE, ☐DURING, OR ☐AFTER ENGINEERING/SAFETY CONTROL USE?
IF NO ENGINEERING/SAFETY CONTROL, DO YOU THINK ONE WOULD HELP? ☐YES ☐NO	IF YES, WHAT TYPE OF ENGINEERING/SAFETY CONTROL?
WHAT PROCEDURAL CHANGES, IF ANY, DO YOU RECOMMEND?	

IF YOU HAVE WORKED FOR THE CITY OF OAKLAND FOR LESS THAN ONE YEAR, LIST ALL EMPLOYERS FOR ONE FULL YEAR PRIOR TO DATE OF INCIDENT, THUS LISTING TOTAL AMOUNT OF ONE FULL YEAR'S EARNINGS INCLUDING TIPS & OTHER BENEFITS IF APPLICABLE:

NAME OF EMPLOYER	ADDRESS	OCCUPATION	FROM			TO			TOTAL $ PAID BY EACH EMPLOYER
			MO.	DAY	YR.	MO.	DAY	YR.	

☐ The above information is true and correct to the best of my knowledge.
☐ I have received the Initial Injury Packet and have completed all necessary forms.

EMPLOYEE'S SIGNATURE:	DATE:

"Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation is guilty of a felony."

This notice has been approved by the Administrative Director of the Division of Workers' Compensation (California Labor Code Section 5401.7)

Initial Distribution: **To Department Workers' Compensation Coordinator in Initial Injury Packet Envelope**
DWCC: Keep original and send copies to Third Party Administrator and Risk Management Division Safety & Loss Control Manager

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CITY OF OAKLAND
AUTHORIZATION FOR EXAMINATION OR TREATMENT

Name: _____ EE ID Number: _____

Job Classification: _____ Date of Birth: _____

Department / Division: (Circle Applicable Dept./ Div.)

DHS Aging	City Administrator/City Clerk	CAO Budget	Finance	Library
City Council	ITD	OPD	OPR	Personnel
OFD	PWA-Equip.	PWA-Maint. PWA-Parks	PWA-Muni. Bldgs.	PWA-Admin
DHS Headstart	CAO Budget	D.O.T	City Attorney	Other: _____

Work Related

❑ Injury ❑ Illness

Date of Injury _____

Substance Abuse Testing (check all that apply)

Drug Screen ❑ DOT ❑ Non-DOT

Breath Alcohol ❑ DOT ❑ Non-DOT

❑ Other: _____

Type of Substance Abuse Testing

❑ Pre-Placement ❑ Reasonable Cause ❑ Post Accident

❑ Random ❑ Periodic ❑ Follow-Up

❑ Return to Work

Physical Examination

❑ Preplacement ❑ Baseline ❑ Annual ❑ Exit

DOT Physical Examination

❑ Pre-Placement ❑ Recertification ❑ Exit

Special Examination

❑ Asbestos ❑ Respirator ❑ Audiogram ❑ Return to Work

❑ Fitness for Duty ❑ Other: _____

Vaccinations / Screening

❑ HBV ❑ HCS ❑ PPD ❑ Other: _____

Billing (check if applicable) ❑ Employee to pay charges

Special Instructions/Comments: _____

_____

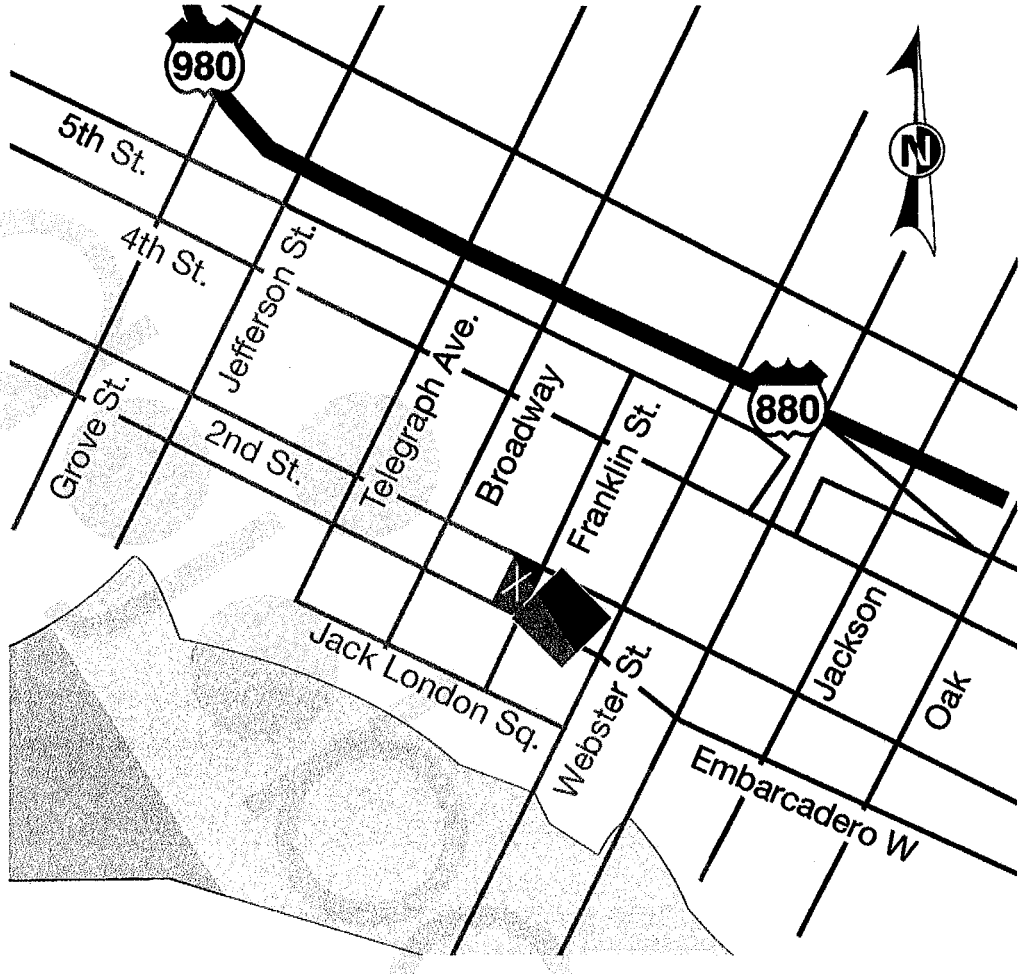
Authorized By: _____ _____

Signature Print

Phone: _____ _____ _____

Date

C0552HAuth



Concentra Oakland
384 Embarcadero W.
1st Floor
Oakland, CA 94607
Mon – Fri: 8 am - 5 pm
510.465.9565
Fax: 510.465.3840

X Free Parking Lot, Space Limited.

Please refer patient back to CONCENTRA Medical Centers with appropriate information so follow up care can be provided by CMC.

C0552HAuth

CITY OF OAKLAND: WORKERS' COMPENSATION MANAGEMENT PROGRAM
DEPARTMENT WORKERS' COMPENSATION COORDINATOR PROCEDURES

CONFIDENTIAL INFORMATION

Retain in Employee's Workers' Compensation file only.

ABILITY STATUS REPORT

To be completed by Treating Physician

EMPLOYEE NAME:	DATE OF INJURY:
SSN:	DEPARTMENT:
EMPLOYER: City of Oakland 150 Frank Ogawa Plaza, 2nd Floor Oakland, CA 94612 Telephone: (510) 238-2270	DIVISION:

APPOINTMENT DATE:	TIME IN: TIME OUT:
NEXT APPOINTMENT DATE:	INJURY TYPE: ☐ Recordable ☐ First Aid

☐ **"Yes, I have reviewed the Employee's Usual & Customary job description prior to addressing work status."**

INJURY/TREATMENT

TYPE OF INJURY:

PHYSICAL THERAPY:

_____ sessions per week for _____ weeks

SURGERY SCHEDULED?:

☐NO ☐YES, DATE: _____

WORK STATUS

☐ A. RELEASED TO USUAL & CUSTOMARY ON *(Date)*:

☐ B. RELEASED TO RESTRICTED DUTY ON *(Date)*:

☐ C. TOTAL TEMPORARY DISABILITY EFFECTIVE *(Date)*:

ANTICIPATED DATE OF MAXIMUM MEDICAL IMPROVEMENT:

WORK ABILITIES

Maximum hours Employee can perform each activity per day

	No restriction	6 hours	4 hours	2 hours	1 hour	0 hours	COMMENTS
Sitting	☐	☐	☐	☐	☐	☐	
Standing/Walking	☐	☐	☐	☐	☐	☐	
Squatting	☐	☐	☐	☐	☐	☐	
Kneeling/Crawling	☐	☐	☐	☐	☐	☐	
Climbing	☐	☐	☐	☐	☐	☐	
Bending	☐	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	☐	
Pushing/Pulling	☐	☐	☐	☐	☐	☐	Weight limitations:
HAND USE:							
Reaching	☐	☐	☐	☐	☐	☐	
Fine Manipulation	☐	☐	☐	☐	☐	☐	
Keyboard/Mouse Use	☐	☐	☐	☐	☐	☐	
Simple Grasping	☐	☐	☐	☐	☐	☐	
Power Grasping	☐	☐	☐	☐	☐	☐	
LIFTING/ CARRYING:							
0-10 lbs.	☐	☐	☐	☐	☐	☐	
11-25 lbs.	☐	☐	☐	☐	☐	☐	
26-50 lbs.	☐	☐	☐	☐	☐	☐	
50+ lbs.	☐	☐	☐	☐	☐	☐	

Can Employee work entire shift?	☐ Yes	☐ No	If no, how many hours?
Does Employee need periodic rest breaks?	☐ Yes	☐ No	If yes, how often?
Can Employee operate/work around moving equipment?	☐ Yes	☐ No	
Can Employee operate a vehicle/apparatus?	☐ Yes	☐ No	
Is Employee on any medication that affects work ability?	☐ Yes	☐ No	If yes, explain:
For Fire Dep't only: Can Employee complete physical agility test?	☐ Yes	☐ No	

PHYSICIAN INFORMATION

NAME:	SIGNATURE:	DATE:
TELEPHONE:	FAX:	E-MAIL:

PHYSICIAN: Give completed original to Employee to return to Department Workers' Compensation Coordinator AND fax to JT2 Integrated Resources at (925) 474-0244

I declare under penalty of perjury that to the best of my information and belief I have not violated California Labor Code Section 139.3 and have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration for any referral for examination or evaluation by a physician.

City Physician: Attach this form to your Confidential Medical Evaluation and Work Restrictions Report.

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION (HIPAA)

You are hereby authorized to furnish JT2 Integrated Resources, or any of their representatives and third party consultants, any and all medical records, medical consultations, medical reports, phone messages and notes under your control and/or under your custodianship pertaining to the undersigned which are relevant to their claim for workers' compensation benefits. This release authorizes disclosure of any and all medical records, and not only those records directly related to treatment of the alleged industrial injury.

The purpose of this requested disclosure is to obtain the medical records necessary to determine the compensability of Applicant's alleged industrial injury and the extent of his/her entitlement to workers' compensation benefits and may also be utilized in determination of the employee's fitness to perform his or her present employment, and in support of return to work determinations.

This authorization will expire 1 year from the date this authorization was signed. A copy of this form shall be effective in lieu of the original. The signee is entitled to a copy of the signed release upon request.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to JT2 Integrated Resources. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation may not apply to the workers' compensation insurance company or adjusting agency handling my claim when the law provides it with the right to contest a claim under the policy. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

A health plan, health care clearinghouse, or a health care provider who transmits any health information in electronic form may not condition treatment, payment, enrollment, or eligibility for benefits on the condition that this authorization be signed. However, I understand that refusal to sign this authorization may affect my ability to receive workers' compensation benefits due to failure to cooperate with the investigation into the compensability of the claim.

Name: _____

Address: _____

_____

_____

DOB: ____ / ____ / _____

Signature: _____

Date: ____ / ____ / _____

Witnessed by: _____

Address: _____

_____

_____

Signature: _____

Date: ____ / ____ / _____

Initial Distribution: **To Department Workers' Compensation Coordinator in Initial Injury Packet Envelope**
DWCC: Send original to JT² Integrated Resources, P.O. Box 8021, Pleasanton, CA 94588

JT2
Integrated Resources

MEDICAL HISTORY INFORMATION

(Labor Code 4663 (d) An employee who claims an industrial injury shall, upon request, disclose all previous permanent disabilities or physical impairments)

Name: _____
Address: _____
_____

Employer: City of Oakland
Claim #: _____
Kaiser #: _____

Please complete for all injuries or impairments prior to date of injury

Medical Provider	Address	Medical Condition or Impairment
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Please return to: **JT2 Integrated Resources**
P.O. Box 8021
Pleasanton, CA 94588

Injured worker's name /
Nombre de la persona lesionada

Claim number / Numero de reclamo

Medical mileage expense form
Forma de gastos por distancia recorrida por visitas medica

If you have to travel to get treatment for your work injury, you are entitled to re-payment of your travel costs. The mileage rate is 56 cents ($.56) per mile. Mileage for reasonable travel to the pharmacy, parking, bridge tolls, public transportation and other travel-related costs are also included. Complete this form. Attach receipts. Send the original to the insurance company and keep a copy. **Do not** send the original or a copy to the local Workers' Compensation Appeals Board (WCAB) or the information and assistance officer. If your travel costs are not paid within 60 days, contact the information and assistance officer.

Si tiene que viajar para recibir tratamiento por una lesión en el trabajo, usted tiene derecho a recibir un reembolso de $.56 por milla. Millas por un viaje de distancia razonable a la farmacia, estacionamiento, pago de peaje, transporte público y otros viajes y costos relacionados estan tambien incluidos. Complete esta forma y adjunte los recibos. Envie la forma original a la compañia de seguros y guarde una copia. **No envie** el original o la copia a la oficina local de la Junta de Apelaciones de Compensación del Trabajador (WCAB). Si sus gastos de viajes no son pagados dentro de 60 dias, llame al oficial de información y asistencia.

Date/ Fecha	**Traveled from** (include address) **Viaje desde** (incluya direccion)	**Traveled to** (include name and address of doctor, hospital, therapist, etc.) **Viaje a** (incluya nombre y direccion del medico, hospital, terapeuta, etc.)	**Round trip mileage/ Millaje viaje redondo**	**Parking/ Estacion-amiento**	**Tolls/ Peaje**
Sample: 1/1/14	Sample: 1515 Maple, San Francisco	Sample: Dr. Sherman, 190 Oak, San Francisco	Sample: 14 mi	Sample: $2.50	Sample: $

California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.	Total miles		x $.56 / mile = $
			Total parking $
			Total tolls $
		Total reimbursement requested	**$**

Las Leyes de California establecen que la siquiente declaraciónaparezca en este fomulario: Cualquier persona que a sabiendas presente reclamos falsos or fraudulentos para el pago de una pérdida, sera culpable de un delito y se le podría multar y encarcelar en la penitenciaría estatal.	**Signature / Firma**
	Printed name / Imprima su nombre
	Date / Fecha

WORK STATUS GUIDE

After each medical appointment, report back in person to your Department Workers' Compensation Coordinator and return the Ability Status Report. Your work status will be determined and you will be advised to take one of the following sets of actions:

A. If you are released to Usual & Customary position (full duty):

- ☐ Obtain a work release from the City Physician according to your Department's procedures.
- ☐ The Department Workers' Compensation Coordinator will give you an Employee Status Memo, which you should give to your Supervisor when you return to work.
- ☐ Return to Treating Physician for any indicated follow up appointments until you are released from care. Bring a completed Ability Status Report back to your Department Workers' Compensation Coordinator in person after each appointment and receive a new Ability Status Report to take to the next appointment.

B. If you have any work restrictions:

- ☐ The Department Workers' Compensation Coordinator will determine if an appropriate Transitional Assignment is available and may work with the Return to Work Specialist if necessary. If an appropriate position is available, review and sign the Transitional Assignment Agreement.
- ☐ If a Transitional Assignment is not available, your Department will keep in touch with you by telephone on a weekly basis during your recovery according to Departmental procedures.
- ☐ Continue treatment with Treating Physician. Return an Ability Status Report to your Department Workers' Compensation Coordinator in person after each appointment and receive a new Ability Status Report for your next appointment.

C. If you are Totally Temporarily Disabled:

- ☐ If you are unable to return to any assignment, your Department will keep in touch with you by telephone on a weekly basis during your recovery according to Departmental procedures.
- ☐ Continue treatment with Treating Physician. Return an Ability Status Report to your Department Workers' Compensation Coordinator in person after each appointment and receive a new Ability Status Report for your next appointment.

Initial Distribution: **Employee Envelope**
Employee: Retain for reference

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OVERVIEW OF CALIFORNIA WORKERS' COMPENSATION SYSTEM

The California Workers' Compensation System is a "no fault" system. Injuries or illnesses that arise out of employment and occur in the course of employment are compensable in accordance with California law. In the event of a work-related injury or illness, the Employee must notify his or her Employer as soon as possible. If the Employer is not notified of the injury/illness within 30 days, the Employee may lose the right to receive Workers' Compensation benefits. Injured Employees are protected from discrimination under California Labor Code Section 132(a). Barring gross negligence, an injured Employee cannot sue his or her Employer. A Workers' Compensation claim is not a lawsuit and does not require an attorney. Any fees for services rendered by the injured Employee's attorney are deducted directly from the injured Employee's benefits received through the Workers' Compensation System. The Workers' Compensation System was established and is closely monitored and controlled by the State of California.

The City of Oakland is self-insured for Workers' Compensation, which means that medical bills and all other benefits are paid from City funds. JT² Integrated Resources administers the City's Workers' Compensation to ensure that all benefits are paid in accordance with California Labor Code regulations. JT² Integrated Resources can be reached at **(800) 582-4671**. If you have questions that cannot be answered by your Department's Workers' Compensation Coordinator or JT² Integrated Resources, contact the City of Oakland's Disability Benefits Coordinator at **(510) 238-2270**. If you are in need of further assistance, you may contact an Information and Assistance Officer at the nearest office of the State Division of Workers' Compensation at **(800) 736-7401**. This information service is free.

The three parts of a Workers' Compensation claim are:

I. **Medical Treatment**
II. **Compensation Payments for Lost Wages**
III. **Claim Resolution**

The State of California has outlined these areas, which are governed by Workers' Compensation Labor Code laws.

I. Medical Treatment

The State of California requires the City of Oakland to provide all reasonable and necessary medical treatment to the injured Employee. The injured Employee pays no deductible and no co-payments. All costs are paid by the City through JT² Integrated Resources for the treating physician, prescriptions, hospital charges, lab fees, therapy, equipment such as crutches, back braces, etc., as well as the injured Employee's mileage for such appointments. The City chooses the treating physician for the first 30 days of treatment if the Employee has not previously designated a treating physician in writing. The City chooses the physical therapist and/or pharmacy for the duration of the claim. The injured Employee should make every effort to schedule follow up appointments, examinations and physical therapy to cause minimal impact on the workday. The number of physical therapy, occupational therapy, and/or chiropractic visits may be limited in accordance with California Labor Code laws; contact JT² Integrated Resources for more information about treatment limitations. Contact the Disability Benefits Coordinator at (510) 238-2270 to determine the City's current designated medical clinic. In the event of an after-hours emergency call for emergency services.

II. Compensation Payments

The State of California requires the City of Oakland to provide compensation to injured Employees who are disabled from work for a period of time. If an Employee is unable to work for more than three days due to a work-related injury/illness, the City will provide the injured Employee with Total Temporary Disability payments* (TTD) through the Third Party Administrator until the treating physician releases the injured Employee back to his or her Usual & Customary position, or until the injured Employee enters a Transitional Assignment, or returns to work with a modification of the Usual & Customary position. Workers' Compensation will pay 2/3 of the injured Employee's Average Weekly Wage up to the California State maximum, which is $728 per week for injuries on or after January 1, 2004, and $840 per week for injuries on or after January 1, 2005. In accordance with the California Labor Code, Total Temporary Disability payments will not be made for the first three days after the injured Employee leaves work unless the period of disability continues for more than 14 days or the Employee is hospitalized as an inpatient for treatment required from the injury. The City also provides Supplemental Pay to eligible Employees; contact your Department Workers' Compensation Coordinator for information regarding your eligibility.

****Public Safety Employees are eligible to receive their full salary in lieu of Temporary Disability for up to one year pursuant to California Labor Code Section 4850.***

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Employees may not be compensated for absences from work due to medical or physical therapy appointments in accordance with the California Labor Code Section 4600 and the City's policy unless such appointments are requested by the City, the TPA, the Administrative Director, the Appeals Board, or a Workers' Compensation judge. Employees may use available ICF or accrued leave to cover lost time.

In the event of a work-related injury resulting in death, the Employee's dependents would be eligible for benefits in accordance with the California Labor Code Section 4700-4709.

For questions regarding compensation, contact your Department's Workers' Compensation Coordinator, or JT² Integrated Resources at **(800) 582-4671**, or the Disability Benefits Coordinator at **(510) 238-2270**.

III. Claim Resolution

The State of California guarantees that when medical treatment has brought the injured Employee to the point of maximum medical improvement and if the injury has resulted in permanent disability residuals (permanent restrictions given by the treating physician), the City is responsible for making a "permanent disability" payment to the injured Employee through the Third Party Administrator. The amount will be determined based on the percentage of disability and in accordance with the established amounts provided by the California Labor Code laws in compliance with Workers' Compensation Code. If permanent restrictions prevent the injured Employee from performing the usual & customary position, the City will engage in an interactive process with the injured Employee to determine if it is possible to offer a Modified Usual & Customary assignment or offer a new Alternative assignment to the Employee within the City of Oakland. This interactive process will be conducted in compliance with the Americans with Disabilities Act and the California Fair Employment and Housing Act. In accordance with California workers' compensation law, a Modified or Alternative position must provide at least 85% of the wages at the time of injury. If Modified or Alternative work is not available, then the injured Employee may be eligible for vocational rehabilitation benefits (if injured prior to 1/1/04) or supplemental job displacement benefits (if injured on or after 1/1/04) or disability retirement.

COMMON TERMS USED FOR WORKERS' COMPENSATION

Date of Injury (DOI): The date that the alleged incident or exposure occurred. The date of injury in cases of occupational diseases or cumulative injuries is that date that the Employee first suffered disability and either knew, or in the exercise of reasonable diligence should have known, that the disability was work-related.

Employee's Claim for Workers' Compensation Benefits (DWC Form 1): Division of Workers' Compensation (DWC) claim form, which is furnished by the Employer and completed by the Employee after an industrial injury.

Employee (EE): The injured Employee.

Employer (ER): The City of Oakland.

Industrial Compensation Free Period (ICF): Supplemental Pay provided by the City to eligible civilian Employees whose injury/illness is accepted as a Workers' Compensation claim. Employees who are unable to work due to either a medical determination of Total Temporary Disability or because an appropriate Transitional Assignment is not available, may be eligible to receive ICF benefits.

Job Description: A description of the required tasks and physical demands of an Employee's Usual & Customary position. A job description will be given to the Treating Physician for use during the Workers' Compensation claim.

Labor Code Section 4850: California Labor Code Section 4850 indicates that when certain Public Safety Employees are temporarily or permanently disabled due to a work-related injury or illness, they are entitled to a leave of absence while so disabled without loss of salary. This benefit is in lieu of temporary disability or maintenance allowance payments, and is only payable during the period of disability for a maximum of one year or until the employee is retired on permanent disability pension and is receiving disability pension payments or advanced disability pension payments.

Transitional Assignment: A temporary assignment provided to an Employee to work during the recovery period of a work-related injury or illness. Transitional Assignments are not known job classifications in the City of Oakland.

Treating Physician (TX): The doctor primarily responsible for managing, monitoring, and reporting about the medical care and treatment of the injured Employee.

Usual & Customary position (U&C): The Employee's regular job at the time of injury (not necessarily the activities performed while injury occurred).

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CITY OF OAKLAND: WORKERS' COMPENSATION MANAGEMENT PROGRAM
INITIAL INJURY PACKET

EMPLOYEE:	_____
SUPERVISOR:	_____
DATE:	_____

INSTRUCTIONS

An injury has occurred. Complete this packet prior to medical treatment unless there is an emergency, in which case call for emergency services.

Employee:

- ☐ Read, complete and sign the Employee portion of the DWC Form 1 "Employee's Claim for Workers' Compensation Benefits."
- ☐ Complete and sign the Employee Incident/Accident Report.
- ☐ Read, complete and sign the Authorization to Disclose Health Information (HIPAA). Have the Supervisor or a co-worker sign as a witness.

Supervisor:

- ☐ Complete the Employer portion of the DWC Form 1 "Employee's Claim for Workers' Compensation Benefits."
- ☐ If this box is checked ☐, complete the 5020 "Employer's Report of Occupational Injury or Illness."
- ☐ Complete and sign the Supervisor Incident/Accident Investigation Report.
- ☐ Contact the Department Workers' Compensation Coordinator to determine if Employee has a pre-designated physician. If not, Employee will receive medical treatment at the City's clinic. Complete the top portion of the Treatment Authorization. *Note: if the DWCC is not available, contact JT² Integrated Resources at (800) 582-4671 to determine if the Employee has a pre-designated physician.*
- ☐ If the Employee's Usual & Customary job description is available, then make two copies. Check the boxes on the Treating Physician Envelope and the Department Workers' Compensation Coordinator Envelope if the U&C job description is available. If the job description is not available, contact the Department Workers' Compensation Coordinator to advise the Third Party Administrator to send the job description to the Physician.

Distribution of forms:
Place completed forms in envelopes as indicated. Distribute envelopes as follows:

- ☐ Employee: Keep Employee Envelope for records and reference.
- ☐ Employee: Bring Treating Physician Envelope to clinic or pre-designated physician.
- ☐ Supervisor: Give the Department Workers' Compensation Coordinator all remaining forms in this envelope.

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TREATING PHYSICIAN ENVELOPE

The injured Employee should bring this packet to the treating physician/clinic at the time of initial treatment. The packet contains the following documents:

- ✓ Treatment Authorization
- ✓ Ability Status Report
- ☐ Usual & Customary Job Description *(Treating Physician: if job description is not enclosed, contact JT² Integrated Resources at (800) 582-4671)*

NOTE TO PHYSICIAN: Please review all materials in this envelope. Employee must receive completed Ability Status Report prior to leaving your office.

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EMPLOYEE ENVELOPE

The Employee should retain the completed forms in this envelope for record keeping and for reference throughout the Workers' Compensation claim. The packet contains the following documents:

- ✓ DWC-1 (6/10 Rev; Page 3) "Employee's Claim for Workers' Compensation Benefits" (Employee's Copy)
- ✓ DWC 1 Coversheet (Rev. 6/10; Pages 1 & 2)
- ✓ Clinic Information
- ✓ Work Status Guide
- ✓ Mileage Reimbursement Form
- ✓ Overview of California Workers' Compensation System

The Employee must return to the Department Workers' Compensation Coordinator with a completed Ability Status Report immediately following the medical visit, or if shift has ended, at the start of the next scheduled shift.

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