Kentucky

BRICKSTREET INJURY KIT

POLICY # WCB1026648

COMPANY NAME Murray State University

CONTACT PERSON AND NUMBER Sarah Leach 270.809.2152

JURISDICTION

Brickstreet® INSURANCE

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INJURED EMPLOYEE CHECKLIST

- Report all injuries to supervisor
  (Alabama, Georgia, Indiana, Iowa, Kansas, Missouri, North Carolina, Pennsylvania, South Carolina, Tennessee and Virginia allow your employer to either choose your physician or provide you with a list of approved physicians)
- Obtain either a full-duty release or a completed Physician Statement of Physical Capabilities form from the doctor (if released for light/modified duty)
- If released to return to work, return on your next scheduled work day with either your full-duty release or the Physician Statement of Physical Capabilities form
- If not released to return to work, you must telephone your supervisor within one business day and provide:
  - Physician's name, address and phone number
  - Date of your next scheduled doctor appointment
- Return Incident Report to your supervisor upon return or within 24 hours

First Fill Information
BrickStreet

Dear Injured Worker,

Optum® has been selected by **BrickStreet** to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply **fill in the form below** and present it at the pharmacy at the time your prescription is filled. This form should ensure that you will have no out-of-pocket expenses when you fill your first prescription.

For your convenience, Optum has an extensive network of retail pharmacies including major chain drug stores.

For pharmacy locations, you may call our toll-free number or visit our website at **cypresscare.com** and use the pharmacy locator in the quick links section of the home page.

If you have any questions, or would like to learn about our convenient home delivery service, please call our customer service number: **1-800-419-7191.**

Estimado Trabajador(a) Lesionado(a),

Optum ha sido seleccionado por **BrickStreet** para asistirle en la obtención de medicamentos relacionados con su reclamo de compensación de trabajadores. Este formulario le permite completar las prescripciones escritas por el médico de sus empleados autorizados de compensación para los medicamentos relacionados con su lesión. Simplemente **llene el siguiente formulario** y preséntelo en la farmacia en el momento que su prescripción está lleno. Este formulario debe asegurarse de que usted no tendrá gastos de su propio bolsillo cuando surte su primera receta.

Para su comodidad, Optum cuenta con una extensa red de farmacias al por menor. De la red de farmacias Optum incluye las siguientes principales cadena de farmacias:

Para localidades de Farmacia adicional, también puede llamar a nuestro número gratuito o visite nuestro sitio web en **cypresscare.com** y usar el localizador de farmacias en la sección de enlaces rápidos de la página de inicio.

Si usted tiene alguna pregunta, o le gustaría aprender acerca de nuestro conveniente servicio al domicilio, llame a nuestro número gratuito de servicio al cliente: **1-800-419-7191.**

First Fill Form: Complete and take to your pharmacy

Bin #: 010876 **Group Number: BRICKSTREET**

Member ID:		Last 4 digits of SSN + date of injury; No spaces (i.e. 9999050206)
Member Name:		Injured worker's first & last name
Employer Name:		
Date of Injury:		

Pharmacy Help Desk: **1-800-419-7191.**

PLEASE NOTE: This form allows you to fill your initial prescriptions with a cost maximum of $150 per prescription and no more than a 14-day supply per prescription. Once your claim has been reviewed, you will be sent a new card in the mail. If you do not receive the pharmacy card, please call us at **1-800-419-7191.**

Issuance of this letter does not constitute acceptance of your claim.

FORM 106
ADOPTED JULY 2003

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
CLAIM NO:_____

MEDICAL WAIVER AND CONSENT

I, _____ having filed a claim for workers' compensation benefits, do hereby waive any physician-patient, psychiatrist-patient, or chiropractor-patient privilege I may have and hereby authorize any health care provider to furnish to myself, my attorney, my employer, its workers' compensation carrier or its agent, the Division of Workers' Compensation Funds, the Uninsured Employers' Fund, or Administrative Law Judge any information or written material reasonably related to my work-related injury occurring on or about _____ any medical information relevant to the claim including past history of complaints of, or treatment of, a condition similar to that presented in this claim or other conditions related to the same body part.

Such information is being disclosed to the purpose of facilitating my claim for Kentucky workers' compensation benefits.

I understand I have the right to revoke this authorization in writing at any time, by sending written notification to each individual health care provider, but such revocation will not have any affect on actions taken prior to revocation. Moreover, inasmuch as KRS 342.020(8) requires a medical waiver to be executed, revocation may result in suspension or delay of the workers' compensation claim.

I understand that no medical provider may condition treatment or payment on whether I sign this medical waiver; however, I further understand that failure to sign this medical waiver may result in suspension or delay of the workers' compensation claim.

I understand that the information used or disclosed pursuant to this medical waiver may be subject to re-disclosure by the recipient.

This authorization shall remain valid for 180 days following its execution. A photocopy of the authorization may be accepted in lieu of the original.

The authorization includes, but is not restricted to, a right to review and obtain all copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

Signed at _____, Kentucky, this _____ day of _____, 20_____.

_____
Signature of Patient Or Personal Representative

Social Security Number: _____

_____
Witness Signature

_____
Description Of Personal Representative's Authority

KENTUCKY WORKERS' COMPENSATION AND HIPAA

On April 14, 2003, the federal Health Insurance Portability and Accountability Act [HIPAA] privacy regulation will take effect. This regulation limits the situations in which medical providers may release patient information, unless the information is necessary for the purpose of treatment, payment, or health care operations. Moreover, it is important to note that disclosures for workers' compensation are in most instances exempt from HIPAA privacy requirements. The exact wording is as follows: "A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation…"

Since HIPAA defers to state law regarding disclosures relating to workers' compensation, it is important for claimants and medical providers to know what Kentucky law requires for disclosure of patient information. An employee who reports a work injury or who files for workers compensation benefits must "execute a waiver and consent of any physician-patient, psychiatrist-patient, or chiropractor-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation." KRS 342.020 (8). Kentucky law further states that once this Form 106 is signed, any health care provider "shall, within a reasonable time after written request by the employee, employer, workers' compensation insurer [or its agent or assignee], special fund, uninsured employers' fund, or the administrative law judge, provide the **requesting party** with any information or written material reasonably related to any injury or disease for which the employee claims compensation."

Once the Form 106 is signed, health care providers may disclose information as set out in Kentucky law. Another section of the regulation allows release of information pursuant to an administrative or judicial order or subpoena, provided that there has been a reasonable effort to notify the injured worker [or his attorney] that such a request has been made. Should there be questions regarding disclosures pursuant to this form, appropriate legal counsel should be consulted or you can contact the Department of Workers' Claims at 1-800 554-8601.

Physician Statement of Physical Capabilities

Return completed form to:

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

Or fax to: 877.898.6980

Claimant Name	Claim Number	Date of Injury

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

Medical Diagnosis

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

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

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

Comments

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

Form 113
Designation of Physician
Revised 03-12-03

Two-Sided Form

COMMONWEALTH OF KENTUCKY
OFFICE OF WORKERS' CLAIMS
Claim No. _____

NOTICE OF DESIGNATED PHYSICIAN

EMPLOYEE: _____
Name

_____
Street Address

_____ ( ) _____
City, State, Zip Telephone Number

_____ _____
Date of Birth Social Security Number

EMPLOYER AT TIME OF INJURY OR LAST EXPOSURE:

_____
Name

_____
Street Address

_____
City, State, Zip

NATURE OF INJURY OR OCCUPATIONAL DISEASE: _____

_____

DATE OF INJURY OR LAST EXPOSURE: _____

FIRST DESIGNATED PHYSICIAN:

_____
Name

_____
Street Address

_____ ( ) _____
City, State, Zip Telephone Number

Accepted by: _____

MEDICAL INFORMATION RELEASE: I hereby waive any privilege I may have to restrict the release of information or written material reasonably related to the work-related injury/disease for which I have sought treatment, and I consent to the release of this information or written material to the medical payment obligor, my employer, Special Fund, Uninsured Employers' Fund, or attorneys representing me or any of the parties named above.

_____ _____
Date Employee Signature

MEDICAL PAYMENT OBLIGOR:

_____
Name Of Obligor

_____
Representative

_____
Street Address

_____ ( ) _____
City, State, Zip Telephone Number

This form identifies the designated physician and must be returned to the medical payment obligor within ten (10) days after treatment begins. An identification card will be provided to the employee, and that card should be presented when medical treatment is required.

Notice: The Workers' Compensation Act requires the employer to pay for the medical services reasonably necessary for cure and relief from the effects of a workplace injury or disease.

The employee may choose the physician (including chiropractors, etc.) who treats him as "designated physician." The designated physician is responsible for the coordination of the employee's medical care and may refer the patient to consulting or treating physicians as required. Except in an emergency, all treatment must be performed by or on referral from the designated physician. The employee may not change his designated physician more than once without the medical payment obligor's consent.

Inquiries shall be made to the listed representative of the medical payment obligor.

This form is not advance authorization from the workers' compensation medical payment obligor for medical services.