

Broome County Office of Risk Management

Broome County Office Building . 60 Hawley Street

P.O. Box 1766, Binghamton, NY 13902 www.gobroomecounty.com

Main Office: Phone (607)778-2402 Fax: (607)778-2918

Workers Compensation Packet and Instructions Effective March 6, 2014

PINK PACKET

1. **Instructions** – to be read by employee (claimant) and supervisor and retained by employee.
2. **C-3 – New York State Employee claim form** to be completed by claimant.
3. **WC Form 1 Claimant’s Statement** – to be completed and signed by claimant.
4. **WC Form 2 Supervisor’s Statement** – to be completed and signed by Supervisor and provided to the Department Head for signature.
5. **WC Form 3 Witness Statement** – to be completed by any and all witnesses of the reported accident/incident. Each witness must complete a separate statement.
6. **WC Form 4 Authorization to Release Records** – to be completed and signed by the claimant.
7. **WC Form 5 Notice to Claimant** – to be signed by the claimant.
8. **WC Form 6 Treating Physicians Report** – to be retained by the claimant and taken to each physician visit.
9. **Cypress Care First Fill Information Form** – to be retained by the claimant and taken to the pharmacy if any medication is prescribed for the injury.

Forms C-3, WC Form 1, WC Form 2, WC Form 3 (all copies), WC Form 4, and WC Form 5 must be submitted to Risk & Insurance

For quicker notifications, the packet can be faxed to (607) 778-2918 or emailed to bcworkerscomp@co.broome.ny.us, but all originals must be forwarded to Risk & Insurance via interoffice mail or through standard mail



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Procedure for Reporting Workers' Compensation Injury

Employee Responsibilities:

1. Notify the supervisor of the accident/incident immediately.
2. The workers compensation packet must be completed, signed and returned to Risk & Insurance within 5 days. Please make sure all forms are fully completed and signed or Risk & Insurance will return them for improper completion.
3. Retain the Pharmacy benefits form, WC Form 6-Treating physicians report and a copy of the packet, for your records.
4. All requests for Diagnostic Testing must be scheduled through our Network. **Failure to schedule through the appropriate network, will result in refusal of payment. All requests for treatment should be faxed to (607) 778-2918, Attention: Workers' Compensation.**
5. **Billing information: The employee is responsible** for notifying the physician of the proper billing information. Be sure to mark the date of injury clearly on all correspondence and make sure all bills are sent to: **Broome County Office of Risk & Insurance Management, P.O. Box 1766, Binghamton, NY 13902-1766**. The treating physicians report must be taken to any and all physician appointments.
6. **Do not pay for Prescriptions!** Information regarding the pharmacy benefits manager is attached and must be provided to the pharmacy with your initial fill.
7. If you have any questions regarding your claim, please call Risk & Insurance at 778-6474.

Supervisor Responsibilities:

- If this is a serious injury and requires transport to a hospital or more than one day out of work, call Risk and Insurance immediately and provide the employees name, brief injury description, employees contact information and treatment facility.
- Review the packet as submitted by the employee and ensure it is completed in full and signed where appropriate. Ensure all forms are returned, including:
 - ✓ the C-3 "Employee Claim"
 - ✓ WC Form 1 – Claimant's Statement of Accident
 - ✓ WC Form 2 – Supervisor's Statement
 - ✓ WC Form 3 – Additional Witness Statements, if applicable
 - ✓ WC Form 4 – Authorization to release records
 - ✓ WC Form 5 – Notice to Employees applying for workers' compensation
- Notify Risk & Insurance immediately via phone or email with any change in work status and fax all physicians reports or doctors notes to (607) 778-2918.
- If you have any questions regarding this paperwork or any additional information regarding this claim, please call 778-6474.

Instructions

Employee Claim

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ 2. Date of Birth: ____/____/____
First MI Last
3. Mailing address: _____
Number and Street/PO Box City State Zip Code
4. Social Security Number: _____ 5. Phone Number: (____) _____ 6. Gender: Male Female
7. Will you need a translator if you have to attend a Board hearing? Yes No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____) _____
3. Your work address: _____
Number and Street City State Zip Code
4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____
6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? Yes No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____
2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) Full Time Part Time Seasonal Volunteer Other: _____
4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____
6. Did you receive lodging or tips in addition to your pay? Yes No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: _____ AM PM
3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? Yes No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: _____
First MI Last

DATE OF INJURY/ILLNESS: ____/____/____

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? Yes No If yes, what? _____
9. Was the injury the result of the use or operation of a licensed motor vehicle? Yes No
If yes, your vehicle employer's vehicle other vehicle License plate number (if known): _____
If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____
10. Have you given your employer (or supervisor) notice of injury/illness? Yes No
If yes, notice was given to: _____ orally in writing Date notice given: ____/____/____
11. Did anyone see your injury happen? Yes No Unknown If yes, list names: _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? Yes, on what date? ____/____/____ No, skip to Section F.
2. Have you returned to work? Yes No If yes, on what date? ____/____/____ regular duty limited duty
3. If you have returned to work, who are you working for now? Same employer New employer Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ____/____/____ None received (skip to question F-5)
2. Were you treated on site? Yes No
3. Where did you receive your first off site medical treatment for your injury/illness? none received Emergency Room
 Doctor's office Clinic/Hospital/Urgent Care Hospital Stay over 24 hours
Name and address where you were first treated: _____
_____ Phone Number: (____) _____
4. Are you still being treated for this injury/illness? Yes No
Give the name and address of the doctor(s) treating you for this injury/illness: _____
_____ Phone Number: (____) _____
5. Do you remember having another injury to the same body part or a similar illness? Yes No
If yes, were you treated by a doctor? Yes No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**

6. Was the previous injury/illness work related? Yes No
If yes, were you working for the same employer that you work for now? Yes No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: ____/____/____

On behalf of Employee: _____ Print Name: _____ Date: ____/____/____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: ____/____/____

Print Name: _____ Title: _____

ID No., if any: R _____ If Licensed Representative, License No.: _____ Expiration Date: ____/____/____

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CLAIMANT'S STATEMENT

Person Injured _____ Social Security# _____
(Last Name) (First Name) (Initial)

Home Address _____

Phone Number _____ Department _____

Date of Incident _____ Time of Incident _____ AM PM Job Title _____

Exact Location of Incident _____

Property/Equipment Involved _____

Describe exactly what happened (attach additional pages if necessary) _____

Describe any Injuries in Detail _____
(attach additional pages if needed)

Witnesses to Incident _____ Witness Department _____ Witness Contact information _____

Attach additional pages if needed

My signature affirms and certifies that the information I have provided is true and accurate, that no false statements or representations or material omissions have been made in support of any claim for payment, and that I understand that that this document will be presented to an insurer and become a part of the records of Broome County.

Signature and title of person preparing report

Date

SUPERVISOR/DEPARTMENT HEAD STATEMENT

Please attach additional pages, if necessary

Date notified of Injury _____ Time notified _____ AM PM _____

Did you witness the Accident/Injury? Yes No

If yes, please describe the incident/accident in detail as witnessed along with employee's condition after injury _____

If No, please state the claimant's account of the injury and your observation of their condition at the time of reporting (i.e limping, cut, bruised, etc)

Do you agree with the claimant's statement of injury? Yes No

If you do not agree with the statement of injury, please explain: _____

Was Personal Protective Equipment required Yes No If Yes, was it used properly Yes No

Please list any unsafe conditions or hazards that caused/contributed to this incident _____

Please note any precautions that should be taken to prevent a similar injury in the future _____

SIGNATURE OF SUPERVISOR

DATE

SIGNATURE OF DEPARTMENT HEAD

DATE



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WITNESS STATEMENT

(Each witness must complete a separate statement)

Attach additional pages, if necessary

Date of Accident/Incident _____ Time of Incident _____ AM PM

Location of Incident _____

Witness Name _____ Witness Job Title _____

Witness Department _____ Witness Phone Number _____

Witness Description of Incident (Include as much detail as possible): _____
(attach an additional page if necessary)

My signature affirms and certifies that the information I have provided is true and accurate, that no false statements or representations or material omissions have been made in support of any claim for payment, and that I understand that this document will be presented to an insurer and become a part of the records of Broome County.

Witness Signature

Date Signed



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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION MUST BE SIGNED FOR PAYMENT OF MEDICAL BILLS

I, _____ authorize the use and disclosure of Health Information as described in this authorization.
Print Name

Specific person/organization or class of persons authorized to provide information:

Licensed physician, medical practitioner, nurse, pharmacist, hospital, clinic, other medical or medically-related facility, insurance or reinsurance company, consumer reporting agency, employer or former employer.

Specific person/organization authorized to receive and use information:

Broome County and legal representatives, POMCO, Inc (or current TPA) and Corporate Care Management, Inc (or current Nurse Case Management Firm)

Specific and meaningful description of the information:

Any and all office notes, diagnostic test results, x-rays, employment records and hospital records.

Purpose of the request:

To evaluate the claim for Workers' Compensation Benefits, to determine causal relationship and/or apportionment.

Right to Revoke:

I understand that I have the right to revoke this authorization at any time by notifying Broome County Office of Risk & Insurance, P.O. Box 1766, Binghamton, NY 13902 in writing. I understand that this revocation is only effective after it is received and logged in by Broome County Office of Risk & Insurance or the current TPA. I understand that this revocation will not apply to any use or disclosure made prior to its activation by Broome County.

I understand that after this information is disclosed, federal law may not protect it and the recipient may re-disclose it for the purposes stated above.

I understand that failure to sign this authorization could result in delayed processing of my claim and the Carrier's inability to pay related medical expenses.

I understand that I may receive a copy of this authorization.

I understand that this authorization will remain in effect for the entire period of my Workers' Compensation claim unless revoked.

Signature of Claimant: _____ Date of Birth: _____

Department employed by: _____ Date: _____



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NOTICE TO EMPLOYEES APPLYING FOR WORKERS' COMPENSATION BENEFITS

If you are applying for or are receiving workers' compensation benefits (including advanced payments of workers compensation in the form of sick, vacation or any other benefit time), you must immediately report any other earnings you receive to the Broome County Office of Risk & Insurance and the Workers' Compensation Board including but not limited to:

1. If you return to any form of work
2. If you held employment of any kind with any other employer at the time of your injury
3. If you are self employed
4. If you receive income from any other sources such as rental property, online sales, etc.
5. If you perform any services in exchange for other goods or services, including volunteer work
6. If there is a change in your contact information including phone number and address
7. If you are participating in any type of educational classes or vocational rehabilitation programs

Failure to report earnings as defined will subject you to criminal prosecution and civil liability, including the suspension or forfeiture of your benefits.

Your endorsement on a benefit check, or deposit of the check into an account, is your statement that you are entitled to receive workers' compensation benefits. Your signature on a benefit check is a further affirmation that you have made no false claims or statements or concealed any material fact regarding your workers' compensation claim.

My signature affirms and certifies that the information I have provided is true and accurate, that no false statements or representations or material omissions have been made in support of any claim for payment, and that I understand that this document will be presented to an insurer and become a part of the records of Broome County.

Date

Claimant Signature

Print Name



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Treating Physician's Workers' Compensation Report To the employee: You must give this form to your physician at each visit

EMPLOYEE NAME _____

DEPT. AND DIVISION _____

DATE OF INJURY _____

For Physician use only

- In your medical opinion is this injury related to the individual's job? Yes No
- Current degree of disability Mild (25%) Moderate (50%) Marked (75%) Total (100%)
- Taking into consideration the degree of disability you identified the employee:
 - Can return to work without restrictions _____ / _____ / _____ Cannot return to work until _____ / _____ / _____
 - Return to work with restrictions indicated below effective _____ / _____ / _____ through _____ / _____ / _____

Broome County has a comprehensive modified duty program & can accommodate most restrictions. The information provided in this form will be utilized to temporarily assign county employees to modified duty. Please explain in detail in the "Additional Comments" the nature of your patient's limitation in terms of Hours / Weight. / Range of Motion, etc.

Additional Comments

<input type="checkbox"/> NO	<input type="checkbox"/> LIMITED	<input type="checkbox"/> UNRESTRICTED	PUSHING	_____
<input type="checkbox"/> NO	<input type="checkbox"/> LIMITED	<input type="checkbox"/> UNRESTRICTED	PULLING	_____
<input type="checkbox"/> NO	<input type="checkbox"/> LIMITED	<input type="checkbox"/> UNRESTRICTED	BENDING	_____
<input type="checkbox"/> NO	<input type="checkbox"/> LIMITED	<input type="checkbox"/> UNRESTRICTED	STOOPING	_____
<input type="checkbox"/> NO	<input type="checkbox"/> LIMITED	<input type="checkbox"/> UNRESTRICTED	SITTING	_____
<input type="checkbox"/> NO	<input type="checkbox"/> LIMITED	<input type="checkbox"/> UNRESTRICTED	STANDING	_____
<input type="checkbox"/> NO	<input type="checkbox"/> LIMITED	<input type="checkbox"/> UNRESTRICTED	TWISTING	_____
<input type="checkbox"/> NO	<input type="checkbox"/> LIMITED	<input type="checkbox"/> UNRESTRICTED	CLIMBING	_____
<input type="checkbox"/> NO	<input type="checkbox"/> LIMITED	<input type="checkbox"/> UNRESTRICTED	KNEELING	_____
<input type="checkbox"/> NO	<input type="checkbox"/> LIMITED	<input type="checkbox"/> UNRESTRICTED	LIFTING	_____ Lbs. Max.
<input type="checkbox"/> NO	<input type="checkbox"/> LIMITED	<input type="checkbox"/> UNRESTRICTED	OVERHEAD LIFTING	_____ Lbs. Max.

Additional restrictions: _____

**Authorization for the following treatment/test is hereby requested:
Requests can be faxed to (607) 778-2918 Attn: Colleen** _____

Date of this Exam: _____ Date of Next Appointment: _____

Physician Signature, Address and Phone Number: _____

I acknowledge and agree to the restrictions as marked above: _____

CLAIMANT'S SIGNATURE REQUIRED

First Fill Information Pomco Group



Dear Injured Worker,

Cypress Care has been selected by **Pomco Group** 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, Cypress Care 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 www.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

Estimado Trabajador(a) Lesionado(a),

Cypress Care ha sido seleccionado por **Pomco Group** 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, Cypress Care cuenta con una extensa red de farmacias al por menor. De la red de farmacias Cypress Care 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 www.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: **800.419.7191**.

First Fill Form: Complete and take to your pharmacy

Bin #: 010876 Group Number: BROOME

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: 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 10-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 800.419.7191.

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