Workers' Compensation Instructions and Information
For FEIN/Participant Employer Representatives

Workers' Compensation insurance provides medical care and compensation to Workers who become injured or disabled at work. As your FMS provider, PICS would like to provide assistance during this process. It is important to educate your Workers on this benefit and explain that it is imperative they report all work-related incidents to you within 24 hours of the date of work injury or illness.

FEIN/Participant Employer Role and Responsibility: When a work accident or injury occurs, you must report all incidents and inform PICS of the event. PICS files all reports on behalf of your *covered workers**. As the Representative, you must ensure the incident is documented thoroughly and accurately. It is crucial to maintain regular communication with the injured Worker and provide PICS' Human Resources Department with the appropriate forms to file the incident with our insurance provider (Nonprofit Insurance Trust). If claims are not submitted on time, penalties may be assessed.

***Covered Workers:** Under MN law, workers who are the parents and/or spouse to FEIN/Participant Employer are exempt from workers' compensation. All other workers (i.e. children, legal guardians, and general household staff) are required to be covered.*

Steps during the Claim Process:

1. When Incident Occurs:

   Worker must notify you and complete **Work Related Injury Report Form** within 24 hours of accident. Both you and the Worker must sign the form. Please provide full details of incident and send completed **Work Related Injury Report Form** to PICS Human Resources. If Worker does not require outside medical attention, you may disregard the remaining forms in this packet.

2. Outside Medical Care (if needed):

   When Worker is injured and would like outside medicate treatment, their place of care is their choice. Worker must contact Human Resources for insurance claim information. Worker must provide you and Human Resources a return-to-work form prior to returning to work.

3. Employer Responsibility before Worker Seeks Medical Care:

   Provide Worker with **Report of Work Ability form** for doctor to complete**, Pharmacy/Insurance Information Form** (incase medication is prescribed), and **Minnesota Workers' Compensation System Informational Sheet**. As the Representative, it is your responsibility to provide the Report of Work Ability form and any other subsequent forms to Human Resources.

4. Worker Responsibilities:

   Completes **Work Related Injury Report Form** and submits to you. Schedules a visit to medical facility (if seeking medical treatment) and fill prescriptions, if applicable. Submits **Work Related Injury Report Form** and **Report of Work Ability Form** to you. You will submit copy to Human Resources. You and the Worker must follow restrictions as outlined by medical provider. Worker continues to attend follow-up visits (if required) until they're released of work restrictions and has reached maximum improvement. Provides any follow correspondence from medical provider to you and PICS Human Resources.

Failure to report may result in penalty or in claim denial. Workers or Representatives making false or misleading statements and claims, or failing to report any work related illness or injury, may be subject to disciplinary action.

PICS Human Resources
hr@picsmn.org
P: 651-967-5064

Work-Related Injury Report Form

This form should be completed by a PICS staff member and be submitted to the PICS HR Administrator as soon as possible after an external worker informs PICS of a work-related injury.

Worker's Personal Information

FULL NAME	BIRTH DATE	HIRED DATE
FULL HOME ADDRESS		
PHONE NUMBER	EMAIL	
REPRESENTATIVE NAME	REPRESENTATIVE'S SERVICE COORDINATOR NAME	
EMPLOYMENT TYPE ☐ PART TIME ☐ FULL TIME	GENDER ☐ MALE ☐ FEMALE	

Injury / Accident Information

DATE OF INJURY	TIME OF INJURY	HAS WORKER RETURNED TO WORK? ☐ YES ☐ NO
DID INJURY CAUSE LOSS OF TIME FROM WORK? (if yes, explain details)	PROVIDE NAMES OF ANY WITNESSES TO ACCIDENT / INJURY	
DESCRIBE INJURY: WHAT PARTS OF THE BODY WERE AFFECTED? WHAT TYPE OF INJURY?		
DESCRIBE WHAT THE WORKER WAS DOING AND HOW INJURY OCCURRED:		

Treatment Information

WAS INJURY TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO	TAKEN BY AMBULANCE? ☐ YES ☐ NO
MEDICAL PROVIDER NAME	MEDICAL PROVIDER PHONE NUMBER
DESCRIBE TREATMENT RECEIVED	

PICS Staff Member Name: _____ **Today's Date:** _____

PICS Staff Member Signature: _____

www.picsmn.org | hr@picsmn.org | Phone: 651-967-5060 | Fax: 651-967-5061 | 1605 Eustis Street, St. Paul, MN 55108

Minnesota Workers' Compensation System
Employee Information Sheet

What does workers' compensation pay for?

- Medical care for the work injury, as long as it is reasonable and necessary
- Wage-loss benefits for part of your lost income (there is a three-calendar-day waiting period before these benefits start)
- Benefits for permanent damage or loss of function of a body part
- Benefits to your spouse and/or dependents if you die of a work injury
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer

How are workers' compensation benefits paid?

Your workers' compensation benefits are paid by an insurance company or your employer, if your employer is self- insured. State law sets the benefit levels. Please note: pursuant to statute, the insurer can obtain medical information specific to your work injury without your authorization.

If the insurer accepts your claim for wage loss benefits and you have been disabled for more than three calendar days:

- The insurer will send you a copy of the *Notice of Insurer's Primary Liability Determination* form stating your claim is accepted.
- The insurer must start paying wage-loss benefits within 14 days of the date your employer knows about your work injury and lost wages. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.

If the insurer denies your claim for wage loss benefits:

- The insurer will send you a copy of the *Notice of Insurer's Primary Liability Determination* form stating it is denying primary liability for your claim. The form must clearly explain the facts and reasons why the insurer believes your injury or illness did not result from your work.
- If you disagree with the denial, you should talk with the insurance claims adjuster who is handling your claim. Your employer's insurance company can answer most questions about your claim.

Insurer name: League of Minnesota Cities Insurance Trust **Phone**: 651-281-1200 **or** 1800-925-1122

- If you are not satisfied with the response you receive from the insurer and still disagree with the denial, you should contact the Department of Labor and Industry at one of the numbers listed below to see what to do next.

If you have other questions or need more help, call:

Minnesota Department of Labor and Industry Worker's Compensation Hoteline:

Twin Cities and Southern Minnesota: **(651) 284-5005 or 1-800-342-5354; TTY (651) 297-4198**
Duluth and Northern Minnesota: **(218) 733-7810 or 1-800-342-5354**

Your call will be answered by experienced workers' compensation specialists, who will provide **instant, accurate information and assistance.**

Additional workers' compensation information is available on the department's Web site at:

www.dli.mn.gov/WorkComp.asp

Your employer is required by law to give you this information. This material can be made available in different formats, such as large print, Braille or audio, by calling the numbers printed above.

Mail or fax to:
MN Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: (651) 284-5731

Report of Work Ability

See Instructions of Reverse Side

Print in ink or type
Enter dates in MM/DD/YYYY format

Reset

RW01

DO NOT USE THIS SPACE

This form must be provided to the employee.
(Minn. Rules 5221.0410,l subd. 6)

NOTICE TO EMPLOYEE: YOU MUST PROMPTLY PROVIDE A COPY OF THIS REPORT TO YOUR EMPLOYER OR WORKERS' COMPENSATION INSURER, AND QUALIFIED REHABILITATION CONSULTANT IF YOU HAVE ONE.

WID number or SSN	Date of injury	Date of birth
Employee		
Employer		
Insurer/Self-insurer-TPA		
Insurer claim number		

Date of most recent examination by this office _____

Select the appropriate option(s) below and fill in the applicable dates.

1. ☐ Employee is able to work without restrictions as of _____ (date)

2. ☐ Employee is able to work with restrictions, from _____(date) to _____(date)

The restrictions are:

3. ☐ Employee is unable to work from _____ (date) to _____(date)

The next scheduled visit is: ☐ as needed OR _____

Name (Type or Print)			**Signature**		**Degree**
Address			**State**	**License #/Registration #**	
City	**State**	**ZIP code**	**Phone # (include area code)**	**Date signed**	

INSTRUCTIONS FOR COMPLETING REPORT OF WORK ABILITY

Each health care provider directing the course of treatment for an employee who alleges to have incurred an injury on the job must complete a Report of Work Ability within 10 days of a request for a Report of Work Ability from the insurer, or at the applicable interval (Minn. Rules 5221.0410, subp. 6):

1. every visit if visits are less frequent that one every two weeks;

2. every 2 weeks if visits are more frequent than once every two weeks, unless work restrictions change sooner; and

3. upon expiration of the ending or review date of the restrictions specified in a previous Report of Work Ability.

The Report of Work Ability must either be on this form or in a report that contains the same information. The Report of Work Ability must:

- Identify the employee by name, WID or social security number, and date of injury.
- Identify the employer at the time of the employee's claimed work injury.
- If known, identify the workers' compensation insurer at the time of the claimed injury, or the workers' compensation third-party administrator. Also indicate this workers' compensation payer's claim number.
- Indicate the date of the most recent examination by this office. The Report of Work Ability should be completed based on this evaluation.
- Identify the appropriate option which best describes the employee's current ability to work by checking box 1, 2, or 3.

  1. If the employee is able to work without restrictions, fill in the beginning date.

  2. If the employee is able to work with restrictions, fill in the date any restriction of work activity is to begin and the anticipated ending or review date. Describe any restrictions in functional terms (e.g., employee can lift up to 20 pounds, 15 times per hour; should have 10 minute break every hour).

  3. If the employee is unable to work at all, fill in the date the restriction of work activity is to begin and the anticipated ending or review date.

- Indicate the date of the next scheduled visit or indicate that additional visits will be scheduled as needed.
- Identify the health care provider completing the report by name, professional degree, license or registration number, address and phone number.
- Include the signature of the health care provider and date of the report.

The health care provider must provide the Report of Work Ability to the employee and place a copy in the medical record.

If you have questions, please call the claim representative or the Department of Labor and Industry, Workers' Compensation Division at (651) 284-5032 or 1-800-342-5354.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

NPIA, INC.
Insurance & Program Administration

21034 Heron Way, Suite 107
Lakeville, MN 55044
Phone: 952.469.5963
claims@npiainc.com

NOTICE TO INJURED WORKER & PHARMACIST:

This temporary First Fill card is only valid if used within 30 days of the reported date of injury. Temporary eligibility through this program allows for a one time fill of prescription medications. For assistance processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.**

Injured Worker's Name: _____ *SS#:* _____
Date of Injury: _____

INJURED WORKER INSTRUCTIONS:

On your first Pharmacy visit, please give this notice to any pharmacy listed on this insert to expedite the processing of your approved Workers' Compensation prescriptions, based on the parameters established by Nonprofit Insurance Trust. With the CorVel pharmacy program, you do not need to complete any paperwork or claim forms. Simply present this CorVel First Fill Prescription Form to the pharmacy. You should not incur any costs or co-pays at the pharmacy and you will be allowed up to a 14-day supply of medications.

PHARMACIST INSTRUCTIONS:
For assistance processing claims please contact the CorVel Pharmacy Department at (800) 563-8438. Please use the BIN, PCN, and RxGroup number below to process an online/electronic claim to CorVel:

CORVEL CVS CAREMARK
Bin: 004336
PCN: ADV
RxGroup: RXFFWC8573370
Member ID: See below to generate ID

TO GENERATE MEMBER ID:

The Injured Worker's 9-digit Social Security Number **plus** the 8-digit Date of Injury will be used as their 17-digit Member Identification number when processing their First Fill Prescription: **XXXXXXXXXMMDDYYYY**

There are over 65,000 Participating Pharmacies in the CorVel Network. Below is a sample listing. Call (800)563-8438 for a participating pharmacy near you.

CostCo Pharmacy	H.E.B. Pharmacies	Meijer Pharmacy	Smith's Food & Drug Centers
CVS	HyVee Pharmacy	Publix Pharmacy	Target Pharmacy
Dominick's Finer Foods	Ingles Pharmacy	Raley's Drug Center	Von's Pharmacy
Drug Mart	Kroger Pharmacy	Rite-Aid Pharmacy	WalMart Pharmacy
Fred's Pharmacy	Longs Drug Store	Safeway Pharmacy	Walgreens Pharmacy
Giant Eagle Pharmacy	Marc's Pharmacy	Sav-On Drug Store	Wegman Pharmacy
Giant Food Stores, LLC	Medicine Shoppe	Shoprite Supermarkets	Winn Dixie Pharmacy

NOTICE TO PROVIDER: Billing information for NPIA, Inc.

E-Billing Information for Minnesota Workers' Compensation / Medical Bill Submission:

CorVel Clearinghouse Electronic Billing- Connectivity issues and questions
Clearinghouse Name: CorVel
Contact: Christy M.
Phone: 612-436-2520 or 877-703-4240
Fax: 1-866-450-9388
Email: stmn_clearinghouse@corvel.com

CorVel Bill Review Customer Service- Questions on actual bill review services/reductions:

Phone: 612-436-2428
E-mail: mn_billreview@corvel.com

Nonprofit Insurance Trust (NPIA) Clearinghouse Payer ID: I1206

Nonprofit Insurance Trust (NPIA) Claims

To obtain a claim number or claim adjuster contact information:

Noreen Schonning, Claims Assistant
Phone: 952-469-5963 ext. 103
E-mail: claims@npiainc.com