Guadalupe County
Human Resources Department

Lois Elley, Human Resource Manager/ Risk Manager

211 W. Court Street, Seguin, Texas 78155 **Phone: (830) 303-8862**

Fax: (830) 401-4960

PROCEDURES FOR FILING & REPORTING WORKERS COMPENSATION INJURIES

Guadalupe County is committed to providing a safe workplace for our employees. Preventing work related illness and injury is our primary goal. We want to maintain a safe environment and see that you receive the appropriate medical treatment for your injury.

If an accident occurs these procedures must be followed:

1. It is the injured employee's responsibility to report his/her accident or incident to their supervisor or department head **immediately.**

2. The supervisor or department head **must** report the injury or incident to Lois Elley (Human Resource Manager/Risk Manager) fax number 830-401-4960 or phone number 830-303-8862 in the Human Resources Department **within 24 hours.**

3. The injured employee **must** submit to a drug and/or alcohol test within 24 hours of any accident/incident or post-accident. All alcohol and drug testing will be done at:

   - **Guadalupe Regional Emergency Room, <u>if injured.</u>** GRMC main line is (830) 379-2411.

   - **Dr. Frank Wright, <u>if injured.</u>** He is located at 411 S. King St. Seguin. Hours are Mondays thru Fridays from 7 a.m. to 7 p.m., the main line is (830) 484-4200. (Employer must take GRMG Treatment Authorization Form).

   - **Guadalupe Regional Urgent Care in New Braunfels, <u>if injured.</u>** They are located at 1751 S. State Hwy 46, Ste 104, New Braunfels, TX 78130. Hours are Sunday through Saturday from 7 a.m. to 7 p.m., the main line is (830)433-7816. (Employee MUST take with them the GRMG Treatment Authorization Form).

   - **Guadalupe Regional Outpatient Lab <u>for drug screen purposes only.</u>** Their hours of operation are between 7:00 a.m. to 4:00 p.m. Monday through Friday. GROL main line is (830) 401-7260.

4. The supervisor or department head **must** complete the First Report of Injury, **<u>NOT</u>** the injured worker and forward this form to Human Resources Department immediately.

5. The injured employee **must** complete the **Employee Injury Statement** and all forms that require an employee signature and forward, along with the First Report of Injury, to the Human Resources Department. Ex. (Medical Release Form, etc.).

6. Any witness to the accident **must** complete the **Witness Statement** form and forward this form to the Human Resources Department along with the First Report of Injury. If there is no witness, please indicate this on the witness statement form.

7. If the employee is going to **miss any work** because of his/her work related injury they must notify their department head or supervisor and his/her adjustor at Tristar, phone # (888) 285-6708. Lost time is only eligible if the treating physician or emergency room doctor takes the employee off work.

8. If the injured employee misses any time from work to attend an office visit, physical therapy, etc. the employee **must** submit a **Leave Request Form** to their supervisor or department head that indicates the time off as workers compensation. The employee may be entitled to post injury wages.

9. The injured employee must tell his or her employer within 30 days of the date of the injury, or within 30 days of the date the worker first knew the illness might be work-related. **If an injured worker does not report his/her injury to their employer within 30 days, they could lose their right to receive benefits.**

Our goal is to see that the injured employee receives the necessary medical treatment for their injury, so that they may return to work as soon as possible.

Guadalupe County will make every reasonable effort to provide suitable return to work opportunities for every employee who is unable to perform his/her regular employee's physical abilities.

If the injured employee is not physically capable of returning to full duty, our return to work program provides opportunities to perform his or her regular job with modifications or, when available, to perform alternate temporary work that meets the injured employee's physical capabilities.

Human Resources and the Deep East Texas Self Insurance Fund are available to assist you with any questions that you may have regarding Workers Compensation Benefits.

TRISTAR Risk Management Workers Compensation:
Ivan Medina
Phone Number - (888) 285-6708 Ext. 2846
Ivan.Medina@tristargroup.net

Please feel free to contact Lois Elley at (830) 303-4188 ext. 1282.

By signing this form, I certify that the above policies and procedures have been explained to me and I understand the instructions provided.

Employee Signature: _____

Employee Name (printed): _____ Date: _____

Work Comp Claim Information

TAKE THIS WITH YOU TO ALL YOUR APPOINTMENTS AND HAVE THEM MAKE A COPY FOR THEIR RECORDS.

CONTACT YOUR ADJUSTER WITHIN 24 HOURS

Claim Adjuster:	TRISTAR Phone:(888) 285-6708 Fax: (214) 492-5691
Billing Address:	**TRISTAR** **PO 2805** **Clinton, IA 52733** **Electronic Billing: WE038 through work comp EDI**
Service Approved:	Initial Evaluation (For further treatment authorization contact the claim adjuster named above)
Pharmacy Benefits:	OnePoint Comp+ Pharmacy Help Desk (886)337-6426
Employer:	Guadalupe County Human Resources Lois Elley - Risk Manager 211 W. Court St. Seguin, TX 78155 Phone: (830) 303-4188 Ext .1282 Fax: (401) 401-4960
Preauthorization Information	Injury Management Organization (IMO) Phone: (877)789-0041 Fax: (877)974-1962
Bill Review	Injury Management Organization (IMO) (877)339-1268

This document acknowledges that the employee has reported a work-related injury. It does not constitute a guaranty of payment beyond the initial visit or compensability, either expressed or implied.

GUADALUPE COUNTY
FIRST REPORT OF INJURY

EMPLOYEE INFORMATION: (ALL INFORMATION MUST BE COMPLETED)

Employee Name: _____ SS#: _____
Last First M.I.

Date of Birth: _____ Home Phone #: (____) ____ - _____ Race: _____ Sex: ☐M ☐F

Mailing Address: _____
Street City State/Zip County

Marital Status: ☐ Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced

Number of Dependent Children: _____ Spouses Name: _____

Length of Service: In Current Position: _____Months _____ Years In Occupation: _____Months _____Years

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INJURY INFORMATION: (ALL INFORMATION MUST BE COMPLETED)

Date of Injury: _____ Time of Injury: _____☐ AM ☐ PM
Was there any lost time: ☐ Yes ☐ No Date Lost Time Began (if applicable): _____

Nature of Injury: ☐ Abrasion ☐ Amputation ☐Allergic Reaction ☐ Bite ☐ Break ☐ Burn ☐Concussion
☐Contusion ☐ Crushed ☐ Contag. Disease ☐ Dislocation ☐ Dust ☐ Eye Injury ☐ Fracture
☐ Foreign Body ☐ Hernia ☐ Heat Exh. ☐ Inflammation ☐ Infection ☐ Laceration ☐ Poison
☐ Puncture ☐ Sprain ☐ Strain ☐ Other

Body Part Injured: ☐ Left ☐ Right
☐ Ankle ☐ Arm ☐ Back ☐ Ear ☐ Elbow ☐ Eye ☐ Finger(s) ☐ Face ☐ Finger(s) ☐ Foot ☐ Groin ☐ Hand ☐ Head
☐ Knee ☐ Leg ☐ Mouth ☐ Neck ☐ Toe ☐ Wrist ☐ Multiple ☐ No injuries ☐ Other _____

How and Why Injury/Illness Occurred: _____

Did you get any type of medical treatment for your injury? ☐Yes ☐ No
If yes, please give the following Doctor/Facility information where treatment was rendered:
Doctor/Facilities Name: _____
Doctor/Facilities Mailing Address: _____
Street City State/Zip
What is expected return to work date? _____
Were you doing your regular job? ☐ Yes ☐ No
Worksite Location of Injury (stairs, side of road, office, etc): _____

Cause of Injury: ☐ Assault ☐ Bite ☐ Burn ☐ Caught Btwn ☐ Cut/Scrape ☐ Exposure ☐ Fall/Slip ☐ Foreign Body
☐ Motor Vehicle ☐ Needle Stick ☐ Sprain ☐ Step ☐ Strain ☐ Strike Against ☐ Other _____

Address where injury occurred: _____
Street City State/Zip County
Witness (es) to incident: _____

Supervisor's Name: _____ Phone Number: (____) ____ - _____

Supervisor's Signature: _____ Date Reported: _____

**********FOR HUMAN RESOURCE USE ONLY**********

DOH: _____ Occupation: _____ Dept: _____
Pay Rate: $_____ Last Pay Check: $_____ for _____hrs NAICS (6 digit) _____ NCCI Code: _____

Revised: 12/08/08 HR

GUADALUPE COUNTY FIRST REPORT OF INJURY

ACCIDENT INVESTIGATION REPORT

Accident Date: _____ Accident Time: _____am/pm Investigation Date: _____

Location at time of accident: _____

_____

Did injury result: Yes No If yes, provide employee(s) name(s): _____

Social Security #: _____ Date of Birth: _____

Describe type of injury: _____

Did property damage result: Yes No

If yes, describe property damage and owner: _____

_____

Name of Witness(es): _____

Description of Accident: _____

_____

_____

Corrective action taken, by whom, and date complete: _____

_____

_____

Was a permit issued? Yes No

If yes, attach a copy of the police report.

_____

Supervisor Signature/Date

GUADALUPE COUNTY FIRST REPORT OF INJURY

INJURED EMPLOYEE'S STATEMENT

Name: _____ Ssn: _____

Address: _____ Phone: ( ) -

_____

Date of Birth: ___/___/_____ Supervisor: _____

Injury Date: ___/___/_____ Injury Time: _____ am/pm

Nature of Injury: _____

Location at time of accident: _____

Describe how the accident/injury occurred:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you refuse medical treatment for this injury? Yes No

_____ _____

Supervisor Signature/Date Employee Signature/Date

GUADALUPE COUNTY FIRST REPORT OF INJURY

WITNESS STATEMENT

Name: _____ SSN: _____

Address: _____ Phone: ( ) -

_____

Date of Birth: ___/___/_____ Supervisor: _____

Location at time of accident: _____

To the best of your knowledge, explain how the injury/accident occurred:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____
Supervisor Signature/Date

_____
Witness Signature/Date

Revised 10/02/2015 HR

GUADALUPE COUNTY FIRST REPORT OF INJURY

Medical Release

_____
Employee Name (Print)

I authorize and request my physician or other person or any hospital or other institution by who, or in which I have received medical treatment for a work-related injury and/or illness, to furnish a representative of Guadalupe County full information relative to such treatment of, or residence in any hospital or institution and to supply said representative with history, reports, consultations, diagnostic films and/or x-rays, or any other medical documentation pertaining to my work-related injury.

A photostatic copy and/or facsimile of this release shall be considered as effective and valid as the original.

_____
Employee Signature

_____
Printed Name

_____/____/_____
Date

Employee – You are required to report your injury to your employer within 30 days of your employer first receives workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division office or 1(800) 252-7031.

Empleado – Es necesario que reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que la división del trabajo que su empleador contrata con la seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte de la Dirección de Compensación para Trabajadores, y también puede tener acceso a ciertos beneficios médicos y económicos. Para mayor información comuníquese con la oficina local de la División al teléfono 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

JUST BRING BACK FROM DR

PART I. GENERAL INFORMATION

1. Injured Employee's Name
2. Date of Injury
3. Employee's Address
4. Employer's Name
5. Clinic/Facility Name
6. Employer's Name
7. Employer's Address
8. Employer's Phone No. (if known)
9. Treating Doctor's Name
10. Treating Doctor's Address
11. Treating Doctor's Phone No.
12. Carrier's Fax # or Email Address (if known)

PART II. WORK STATUS INFORMATION

13. This injured employee's medical condition resulting from this work-related injury:
- ☐ (a) will allow the employee to return to work as of _____ (date) without restrictions.
- ☐ (b) will allow the employee to return to work as of _____ (date) with the restrictions identified in PART III, which are expected to last through _____ (date).
- ☐ (c) has prevented and still prevents the employee from returning to work as of _____ (date) and is expected to continue through _____ (date). The following describes how this injury prevents the employee from returning to work:

PART III. WORK RESTRICTIONS (ONLY COMPLETE IF BOX 13(b) IS CHECKED)

14. POSTURE RESTRICTIONS (if any):

	Max Hours per day: 0	2	4	6	8	Other
Standing	☐	☐	☐	☐	☐	
Sitting	☐	☐	☐	☐	☐	
Kneeling/Squatting	☐	☐	☐	☐	☐	
Bending/Stooping	☐	☐	☐	☐	☐	
Pushing/Pulling	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	
Other: _____	☐	☐	☐	☐	☐	

17. MOTION RESTRICTIONS (if any):

	Max Hours per day: 0	2	4	6	8	Other
Walking	☐	☐	☐	☐	☐	
Climbing stairs/ladders	☐	☐	☐	☐	☐	
Grasping/Squeezing	☐	☐	☐	☐	☐	
Wrist flexion/extension	☐	☐	☐	☐	☐	
Reaching	☐	☐	☐	☐	☐	
Overhead Reaching	☐	☐	☐	☐	☐	
Keyboarding	☐	☐	☐	☐	☐	
Other: _____	☐	☐	☐	☐	☐	

18. MISC. RESTRICTIONS (if any):
- ☐ Max hours per day of work: _____
- ☐ Sit/Stretch breaks of _____ per _____
- ☐ Must wear splint/cast at work
- ☐ Must use crutches at all times
- ☐ No driving/operating heavy equipment
- ☐ Can only drive automatic transmission
- ☐ No work / ☐ _____ hours/day work
  - ☐ In extreme hot/cold environments
  - ☐ At heights or on scaffolding
- ☐ Must keep _____:
  - ☐ Elevated ☐ Clean & Dry
- ☐ No skin contact with: _____
- ☐ Dressing changes necessary at work
- ☐ No Running

15. RESTRICTIONS SPECIFIC TO (if applicable):
- ☐ L Hand/Wrist ☐ R Hand/Wrist
- ☐ L Arm ☐ R Arm ☐ Neck
- ☐ L Leg ☐ R Leg ☐ Back
- ☐ L Foot/Ankle ☐ R Foot/Ankle
- ☐ Other: _____

18. LIFT/CARRY RESTRICTIONS (if any):
- ☐ May not lift/carry objects more than ____ lbs. for more than ____ hours per day
- ☐ May not perform any lifting/carrying
- ☐ Other: _____

16. OTHER RESTRICTIONS (if any):

20. MEDICATION RESTRICTIONS (if any):
- ☐ Must take prescription medication(s)
- ☐ Advised to take over-the-counter meds
- ☐ Medication may make drowsy (possible Safety/driving issues)

* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty does not exist, these restrictions do not apply, the patient should be considered to be off work. Note – these restrictions should be followed outside of work as well as at work.

PART IV. TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

21. Work Injury Diagnosis Information:

22. Expected Follow-up Services Include:
- ☐ Evaluation by the treating doctor on _____ (date) at ____ : ____ am/pm
- ☐ Referral to/Consult with _____ on _____ (date) at ____ : ____ am/pm
- ☐ Physical medicine ___ X per week for ___ weeks starting on _____ (date) at ____ : ____ am/pm
- ☐ Special studies (list): _____ on _____ (date) at ____ : ____ am/pm
- ☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date / Time of Visit	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type:	Role of Doctor:	
Discharge Time			☐ Initial ☐ Follow-up	☐ Designated doctor ☐ Carrier-selected RME ☐ DWC-selected RME	☐ Treating doctor ☐ Referral doctor ☐ Casualty doctor ☐ Other doctor

GUADALUPE REGIONAL MEDICAL GROUP

GRMG Treatment Authorization – Employee Services

Company Name: ____Guadalupe County_____

Address: ____211 W. Court St. Seguin, TX 78155_____

Phone: __(830) 303-8862__ After hours phone: _(830) 660-8611_ Fax: (830) 401-4960__

Person authorizing treatment (print name): _____Lois Elley_____

Email address of person authorizing treatment: ___Lois.Elley@co.guadalupe.tx.us_____

Employee Name: _____

Date of Injury: _____

Social Security Number: _____ DOB: _____

Date Authorization Expires: _____ Time: _____

Service Requested: __Treatment for work related injury_____

Medical Evaluation:

- ■ Work Related Injury
  (Job description required)

Drug/Alcohol Testing:

- ■ Post-Accident
- ☐ Random
- ☐ Pre-Employment
- ■ Other: _BAT (Breath & Alcohol Test)_
- ☐ For Cause
- ☐ Follow up (DOT)
- ☐ Return to DOT (DOT only)

DWC Form-73 to be given to:

- ☐ Employee
- ☐ Fax to Employer:

  Guadalupe County
  Lois Elley
  Human Resources Manager/ Risk Manager
  Fax (830) 401-4960
  Phone (830) 303-4188 Ext 1282

- ☐ Fax to TML:

  TriStar Risk Management
  5525 N. MacArthur Blvd. Suite 250
  Irving, TX 75038-2681
  Fax (214) 492-5691
  Phone (888) 285-6708 Ext 2818

Clinic location:

Frank Wright, M.D.
411 S. King, Ste A
Seguin, TX 78155
P (830) 484-4200
F (830) 386-0891

Guadalupe Regional Urgent Care in Clear Springs
1751 S. State Hwy 46, Ste 104
New Braunfels, TX 78130
P (830) 433-7816

Guadalupe Regional
MEDICAL CENTER

1215 E. Court Street
Seguin, TX 78155
830.401.7237
FAX 830.401.7588
www.grmedcenter.com

AUTHORIZATION TO RELEASE/ACCESS PROTECTED HEALTH INFORMATION

Patient Name _____

Date of Birth _____ SSN _____ Phone _____

Address _____ City_____ ST _____ Zip _____

I authorize Guadalupe Regional Medical Center, or business associate working on their behalf, to release information contained in the medical record on the patient identified above. Information released/requested will cover the following dates of service: From _____ Through _____

Information Released:

- ☐ Consultation Report
- ☐ Discharge Summary
- ☐ Emergency Room Records
- ☐ Entire record (excludes Psychotherapy notes)
- ☐ Laboratory Reports
- ☐ Operative Report
- ☐ Pathology Reports
- ☐ Other _____
- ☐ Radiology Studies (CD only)
- ☐ Therapy Records

Purpose of Request: ☐ Continued Treatment ☐ Third Party Payment/Insurance* ☐ Legal Review* ☐ Other (Specify)* _____ ☐ Personal Review*

Medical Records will be delivered as follows: (Check only one box)

- ☐ I will pick up copies of my records
- ☐ Records will be picked up by _____ (photo ID required)
- ☐ Provide my records to the **physician/facility** listed below:

Name/Organization	
Address	
Phone	

I understand:

- I may revoke this Authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless revoked earlier, the expiration date of this Authorization will be 90 days from the date of signature.
- That information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by privacy regulations.
- The information authorized for release may include protected health information related to mental health or substance use/abuse. Release of mental health records or psychotherapy notes my require consent of the treating provider or court order.
- If the requested portion of the record contains information pertaining to mental health, drug or alcohol treatment, or HIV related information; you must specifically authorize the release of such information to the above named recipient by initialing: Yes _____ (initial) or No _____ (initial)
- That Guadalupe Regional Medical Center will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I provide this authorization.
- I may request a copy of this signed authorization for my records.

_____ _____ _____

Signature of Patient or Patient's Legal Representative** Relationship to patient Date Signed

*Fees apply **May be required to show proof of representative status

OnePoint® COMP+

TRISTAR

INSTRUCTIONS FOR PRESCRIPTION BENEFIT CLAIMS

Dear Injured Worker:

The below temporary COMP+ prescription benefit card will authorize you to obtain prescription medications for your work-related injury, with no out-of-pocket expense. The card will be activated when the pharmacy processes the prescription medication along with all necessary information. Once activated, it will authorize you to obtain prescription medications that are directly related to your work injury. *NOTE: there may be limitations to how much of your prescription may be dispensed, based on various elements such as jurisdictional and/or other restrictions in place for your employer's prescription benefit plan.*

Please note that this card is to be used only for prescriptions related to your work injury. Should you attempt to use it for other prescriptions not related to the work injury, it will become your responsibility to pay for those prescriptions. Please avoid having any prescription related to your work injury filled directly by the prescribing physician's office, as most physicians do not accept prescription benefit cards for billing purposes.

You may fill your prescriptions at the COMP+ network pharmacy of your choice, which includes all of the major retail pharmacies. Need help finding your nearest network pharmacy? Call COMP+ at 1-866-337-6426 for assistance. For other questions regarding your work-related injury, please call 1.888.55TRISTAR (1.888.558.7478) to contact your TRISTAR claim examiner.

Your temporary COMP+ prescription benefit card contains important claims and customer service information for you and your pharmacist. Please present the lower portion of this letter to your pharmacist when filling any prescription related to your work injury. A permanent card may be mailed to replace this temporary card.

OnePoint® COMP+

TRISTAR

Workers Compensation Rx Benefit Card

Rx BIN: 610243
Rx PCN: WC
Rx Group: TMCMOFTXT2
Rx ID: TMC01

This card is for Pharmacy Benefits Managed by OnePoint Patient Care

First Fill Only

Employee Name: _____

Employer Name: _____

Injury Date: _____

Present this card along with your prescription when ordering your medication. If you have any questions regarding your pharmacy benefit program, please call Customer Service 7 days a week/24 hours a day.

For Employees/Pharmacists: 866-337-6426

Card Instructions: Pharmacy should submit claims using the workers' compensation claim segment. This is an interim prescription benefit card and can only be used for an injured worker's first prescription fills.

Card will activate upon prescription submission

If you have any issues filling a prescription, please contact the Pharmacy Help Desk number listed above.

Printed 7/1/2020

OnePoint® COMP+

TRISTAR

INSTRUCCIONES PARA LAS SOLICITUDES DE BENEFICIOS DE RECETAS MÉDICAS

Para el/la trabajador/a lesionado/a:

La tarjeta temporal de beneficios de recetas médicas de COMP+ que se encuentra adelante le permitirá obtener los medicamentos recetados para su accidente de trabajo sin costos adicionales. La tarjeta se activará cuando la farmacia procese el medicamento recetado junto con toda la información necesaria para la administración de los beneficios de la farmacia. Una vez activada, podrá obtener los medicamentos recetados en particular para su accidente de trabajo. *NOTA: pueden haber limitaciones en cuanto a la cantidad de recetas médicas que se pueden brindar. Esto puede depender de distintas condiciones como las restricciones jurisdiccionales o de otro tipo establecidas para el plan de beneficios de recetas médicas de su empleador/a.*

Recuerde que esta tarjeta solo deberá utilizarse para las recetas médicas para su accidente de trabajo. Si intentase utilizarla para cualquier otra receta médica no relacionada con su accidente de trabajo, será su responsabilidad pagar aquellas recetas. Evite obtener cualquier receta médica para su accidente de trabajo en un consultorio médico, ya que la mayoría de los/las médicos/as no aceptan tarjetas de beneficios de recetas médicas por motivos de facturación.

Puede solicitar sus recetas médicas en cualquier farmacia de la red COMP+ que desee, que incluye todas las farmacias minoristas principales. ¿Necesita ayuda para encontrar la farmacia más cercana a su domicilio? Llame a COMP+ al 1-866-337-6426 para obtener más ayuda. Si tiene otras preguntas relacionadas con su accidente de trabajo, llame al 1.888.55TRISTAR (1.888.558.7478) para comunicarse con un/a administrador/a de reclamos de TRISTAR.

Su tarjeta temporal de beneficios de recetas médica de COMP+ contiene datos importantes e información de servicio al cliente para usted y su farmacéutico. Entréguele la parte inferior de esta carta a su farmacéutico al momento de solicitar cualquier medicamento recetado para su lesión laboral. Es posible que reciba por correo una tarjeta permanente para reemplazar esta tarjeta temporal.

OnePoint® COMP+ TRISTAR

Workers Compensation Rx Benefit Card

Rx BIN: 610243
Rx PCN: WC
Rx Group: TMCMOFTXT2
Rx ID: TMC01

This card is for Pharmacy Benefits Managed by OnePoint Patient Care

First Fill Only

Employee Name: _____

Employer Name: _____

Injury Date: _____

Present this card along with your prescription when ordering your medication. If you have any questions regarding your pharmacy benefit program, please call Customer Service 7 days a week/24 hours a day.

For Employees/Pharmacists: 866-337-6426

Card Instructions: Pharmacy should submit claims using the workers' compensation claim segment. This is an interim prescription benefit card and can only be used for an injured worker's first prescription fills.

Card will activate upon prescription submission

If you have any issues filling a prescription, please contact the Pharmacy Help Desk number listed above.

Printed 7/1/2020

modern MEDICAL INCORPORATED
ONE LESS THING TO WORRY ABOUT

WE ARE HERE FOR YOU.

As a strategic partner with Tristar Risk Management and Deep East Texas Self Insurance Fund we provide non-Pharmacy services on your claim. This includes medical equipment needs. Therefore, if your treating physician needs to order medical equipment, please provide their office with the information below.

If your treating physician prescribes you any medical equipment or equipment supplies resulting from your work related injury, please contact Modern Medical, Inc.

Phone: 800-547-3330

- Our standard hours of service are from 7:30 am to 9:00 pm EST.
- Emergency requests after hours are responded to via our 24 hour paging service, which is staffed by managers and specialists.

Key Department Contacts
Phone: (800) 547-3330
Fax: (877) 247-3330

Billing & A/R Recovery	Melissa Sigman *Director, Billing & A/R Recovery*, Ext. 1252 msigman@modernmedical.com
Client Support	Eric Andreini *Client Support Manager*, Ext. 1301 eandreini@modernmedical.com
Clinical Services	Robin Thompson *Clinical Services Manager*, Ext. 1215 rthompson@modernmedical.com
Durable Medical Equipment	Valerie LeMaster *DME Supervisor*, Ext. 1266 vlemaster@modernmedical.com
Electrotherapy	Jamie Mank *Electrotherapy Manager*, Ext. 1201 jmank@modernmedical.com
Pharmacy	Misty Wedding *Senior Pharmacy Manager* – 1st Shift, Ext. 1207 mwedding@modernmedical.com Sarah Smith *Pharmacy Manager* – 2nd Shift, Ext. 1203 ssmith@modernmedical.com
Transportation, Translation, Home Health & Purchasing	Jessica Fisher *TT/HH & Purchasing Manager*, Ext. 1270 jfisher@modernmedical.com