

**OWEN COUNTY BOARD OF EDUCATION
1600 HWY 22 EAST
OWENTON, KY. 40359
502-484-4003
Fax – 502-484-9095**

**WORKERS COMPENSATION GUIDELINES
Effective March 1, 2010
BLUEGRASS HEALTH NETWORK, INC.**

- 1. Complete Workers Compensation Packet.**
- 2. Take this sheet, medical waiver/consent form & pharmacy form to the provider on the alleged claim. A card will be issued at the time incident is filed.**
- 3. The supervisor's report and 1A-1 form will need to be turned in to me in order for claim to be processed in a timely manner.**

WE ARE UNDER A MANAGED CARE PROVIDER AS ALWAYS. IF YOU HAVE QUESTIONS ABOUT OTHER PROVIDERS, PLEASE CONTACT ME AT 502-484-4003.

**MANAGED CARE DOCTORS (LOCAL)
OWEN COUNTY CLINIC
NEW HORIZON MEDICAL CENTER**

**PLEASE SUBMIT ALL WORKERS COMP. CLAIMS TO:
Bluegrass Health Network, Inc.
P.O. Box 23770
Louisville, Ky. 40223**

**PHONE: 800-928-1342
FAX: 502-489-6430 or 502-489-6435**

Questions: Contact Barbara Sharp, 502-484-4003

IA-1

WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL. ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE
		JURISDICTION	JURISDICTION CLAIM NUMBER	
SIC CODE	EMPLOYER FEIN	INSURED REPORT NUMBER	LOCATION NO.	PHONE NUMBER
EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT):				

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)		POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NUMBER)	
Seneca Risk Services, Inc. P.O. Box 99369 Louisville, Kentucky 40269 (800)-442-5723		To	US&C (BHN-MCO) P.O. Box 23770 Louisville, Kentucky 40223 (800)-928-1342 or (502)-245-8012 Fax: (502)-489-6435	
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	CHECK IF APPROPRIATE	SELF INSURANCE	
				ADMINISTRATOR FEIN
AGENT NAME AND CODE NUMBER				

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER		DATE HIRED	STATE OF HIRE	
ADDRESS (INCL. ZIP)		SEX	MARITAL STATUS		OCCUPATION/JOB TITLE		
PHONE		M MALE	U UNMARRIED (SINGLE/DIVORCED)	EMPLOYMENT STATUS			
		F FEMALE	M MARRIED	NCCI CLASS CODE			
		U UNKNOWN	S SEPARATED				
		# OF DEPENDENTS	K UNKNOWN				
RATE	PER	DAY	MONTH	# DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY?	YES	NO
		WEEK	OTHER		DID SALARY CONTINUE?	YES	NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	AM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	AM	LAST WORK DATE	DATE EMPLOYEE NOTIFIED	DATE DISABILITY BEGAN
	PM			PM			
CONTACT NAME/PHONE NUMBER		TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED		
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYERS PREMISES?		TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE		
<input type="checkbox"/> Yes <input type="checkbox"/> No							
DEPARTMENT OF LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL							CAUSE OF INJURY CODE
DATE RETURNED TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?		YES	YES		
		WERE THEY USED?		NO	NO		
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)		INITIAL TREATMENT			
				0 NO MEDICAL TREATMENT			
				1 MINOR BY EMPLOYER			
				2 MINOR CLINIC/HOSP			
				3 EMERGENCY CARE			
				4 HOSPITALIZED > 24 HOURS			
				5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED			
WITNESS (NAME & PHONE #)		DATE ADMINISTRATOR NOTIFIED		DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER	

IA-1 (2/95)

SEE BACK FOR IMPORTANT STATE INFORMATION/SIGNATURE

Supervisor's Accident Investigation Report

(The Completion of this report is not an admission of liability on the part of the employer. Use this if you feel a claim is suspicious, or pick up the phone and call your claims adjuster.)

Employer			
Name of Injured			
Date of Injured	Hour	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Department
Nature of Injury			
Describe Occurrence			
Please Check Appropriate Cause:			
		<input type="checkbox"/> Unsafe Condition	<input type="checkbox"/> Unsafe Practice
Please check appropriate answer:		Yes	No
Was person properly instructed		<input type="checkbox"/>	<input type="checkbox"/>
Was a known safety rule violated?		<input type="checkbox"/>	<input type="checkbox"/>
Were proper safety appliances in use?		<input type="checkbox"/>	<input type="checkbox"/>
Is injured a repeater?		<input type="checkbox"/>	<input type="checkbox"/>
In YOUR opinion, what actually caused the accident?			
What have YOU done to prevent a similar accident?			
Date of Report		Foreman's Signature	

BHN

BLUEGRASS HEALTH NETWORK/

Providing Managed Care Services

P.O. Box 23770 • Louisville, Ky. 40223

(800)-928-1342 • (502)-245-8012 • Fax (502)-489-6435

UNDERWRITERS SAFETY & CLAIMS, INC.

TPA (Third Party Administrator)

KENTUCKY

DEPARTMENT OF WORKERS CLAIMS

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 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 for the purpose of facilitating my claim for Kentucky workers compensation benefits.

I understand that 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 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

Description of Personal Representative's Authority

(Injured worker should take this form to his BHN physician. The physician will then release treatment information to BHN and US&C so the claim can be processed.)



Seneca Risk Services, Inc.
Workers Compensation
RX Benefits

*Please take this flyer to your local pharmacy for your
Work Comp Prescriptions*

CALL PMN 888-586-4650 FOR MEMBER ID #

BIN # 004758

PCN: NPS

Group # PMN1047

MEMBER ID #

PERSON CODE: 00

PATIENT FIRST NAME, LAST NAME, ADDRESS AND PHONE NUMBER
ARE REQUIRED TO BE SUBMITTED FOR PAYMENT

PROGRAM ADMINISTRATOR:

Preferred Medical Network

1-888-586-4650

Only muscle relaxants, anti-inflammatory and
pain killers are AUTHORIZED

Prior authorization is required for all other medications

CALL ON ALL REJECTIONS and
PRIOR AUTHORIZATIONS

1-888-586-4650



BHN

EMPLOYEE CARD (SAMPLE)

An employee identification card is to be presented to the BHN provider at the time of treatment. This is a communication tool to notify the provider to communicate with BHN.

**BHN/
BLUEGRASS HEALTH NETWORK**

P.O. Box 23770, Louisville, Kentucky 40223

For work-related injuries call

Louisville: (502)-245-8012

Statewide: 1-(800)-928-1342

24-Hour Access • 7 Days a Week

**This card is not a guarantee of eligibility for
Workers' Compensation Benefits**

Health Care Providers

BHN has engaged to review medical bills. For hospital admission and billing information, please call the number on the front of the card.

Physicians:

Contact BHN for admission authorization at least 48 hours prior to non-emergency admission. For emergency admission, contact BHN within 24 hours of admission.

Please call BHN with questions or concerns.