TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS

CLAIMS ADM/CARRIER

JURISDICTION CLAIM # (STATE FILE #)

CLAIMS ADM CLAIM # (INSURER CLAIM #)

OSHA LOG CASE #

CLAIM TYPE CODE
- ☐ MED ONLY
- ☐ INDEMNITY
- ☐ BECAME LOST TIME
- ☐ BECAME MED ONLY
- ☐ NOTIFY ONLY
- ☐ TRANSFER

NAME OF INSURANCE CARRIER: Berkley Casualty Company

CARRIER FEIN

CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)

FEIN OF CLMS ADM

CLAIMS ADJUSTER NAME

CLMS ADJ PHONE #

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE TENNESSEE WORKERS' COMPENSATION LAW AND MUST BE COMPLETED AND FILED WITH YOUR INSURANCE CARRIER IMMEDIATELY AFTER NOTICE OF INJURY.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS' COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

IF YOU HAVE QUESTIONS, THE STATE NOW HAS A BENEFIT REVIEW SYSTEM WHERE A WORKERS' COMPENSATION SPECIALIST CAN PROVIDE ASSISTANCE. CALL 1-800-332-2667 (TDD).

CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2: P.O. Box 49129

CITY: Greensboro | STATE: NC | ZIP: 27419

EMPLOYER

EMPLOYER NAME: Sumner County Board of Education

EMPLOYER FEIN: 62-0681064

SIC CODE

PHONE NUMBER: 615-451-5200

EMPLOYER ADDRESS LINE 1 AND LINE 2: 685 E. Main Street

NATURE OF BUSINESS: School District

CITY: Gallatin | STATE: TN | ZIP: 37066

INSURED REPORT #

EMPLOYER LOCATION

POLICY

INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)

POLICY NUMBER: KEY0145256

SELF INSURED? ☐ YES ☒ NO

EFF DATE: 07/01/2023

EXP DATE: 07/01/2024

EMPLOYEE

EMPLOYEE LAST NAME

PHONE INCL AREA CODE

FIRST | MI

DEPARTMENT REGULARLY WORKED

GENDER
- ☐ MALE
- ☐ FEMALE
- ☐ UNKNOWN

EMPLOYMENT STATUS CODE
- ☐ FULL TIME/REGULAR
- ☐ PART TIME
- ☐ PIECE WORKER
- ☐ SEASONAL
- ☐ VOLUNTEER
- ☐ APPRENTICE FULL TIME
- ☐ APPRENTICE PART TIME

ADRRESS LINE 1 & 2

OCCUPATION DESCRIPTION

CITY | STATE | ZIP

MARITAL STATUS
- ☐ UNMARRIED, SINGLE, DIVORCED
- ☐ MARRIED
- ☐ SEPARATED
- ☐ UNKNOWN

NCCI CLASS CODE

SSN | DATE OF BIRTH | DATE OF HIRE

WAGE

WAGE $

PERIOD
- ☐ HOURLY
- ☐ DAILY
- ☐ WEEKLY
- ☐ BI-WEEKLY
- ☐ MONTHLY

NUMBER OF DAYS WORKED PER WEEK

SALARY CONTINUED IN LIEU OF COMPENSATION ☐ YES ☐ NO

FULL WAGES PAID FOR DATE OF INJURY ☐ YES ☐ NO

ACCIDENT/INJURY

DATE OF INJURY

TIME OF INJURY ☐ AM ☐ PM
☐ COULD NOT BE DETERMINED

TIME EMPLOYEE BEGAN WORK ON INJURY DATE ☐ AM ☐ PM

DATE EMPLOYER NOTIFIED OF INJURY

BODY PART AFFECTED CODE

NATURE OF INJURY CODE

CAUSE OF INJURY CODE

DATE CLAIM ADM NOTIFIED OF INJURY

HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE INCIDENT INCLUDING WHAT THE EMPLOYEE WAS DOING JUST BEFORE, THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY HARMED THE EMPLOYEE.

DATE LAST DAY WORKED

DATE DISABILITY BEGAN

RETURN TO WORK DATE (IF APPLICABLE)

DATE OF DEATH (IF APPLICABLE)

IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP
- ☐ WIDOW
- ☐ WIDOWER
- ☐ MOTHER
- ☐ FATHER
- ____ DAUGHTER
- ____ SON
- ____ SISTER
- ____ BROTHER
- ____ HANDICAPPED CHILD

TOTAL # DEPENDENTS

DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)

CITY | STATE | ZIP

COUNTY OF INJURY

TREATMENT

PHYSICIAN NAME

HOSPITAL OR OFF SITE TREATMENT NAME

ADDRESS LINE 1 AND 2

ADDRESS LINE 1 AND 2

CITY | STATE | ZIP

CITY | STATE | ZIP

INITIAL TREATMENT
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR BY EMPLOYER
- ☐ MINOR BY CLINIC/HOSPITAL
- ☐ HOSPITALIZED > 24 HRS
- ☐ EMERGENCY CARE
- ☐ FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

OTHER

DATE PREPARED

PREPARER'S NAME & TITLE

PREPARER'S COMPANY NAME

PHONE NUMBER

RDA 10183

LB-0021 (REV. 12/07)

#1

Key Risk
a Berkley Company

Authorization

The undersigned has filed a claim for workers compensation benefits (hereinafter referred to as the "Claim"). The amount and type of information sought pursuant to this authorization will depend upon the nature of the Claim, but will be used solely to facilitate determination regarding the validity of the Claim and the payment of benefits or the administration of the insurance program under which the Claim has been made. Authorizing the disclosure of information is voluntary, and acceptance of the Claim will not be conditioned upon signing this authorization. This authorization is subject to revocation at any time, except to the extent that any party has already acted in reliance upon it. Any revocation must be submitted in writing to Key Risk, P.O. Box 14817, Lexington, KY 40512.

The undersigned authorizes the release of information and communication between my health care provider(s) (including without limitation, medical laboratories, pharmacies, and medical suppliers) and representatives of Key Risk Management Services/ Berkley Insurance Company ("Key Risk").

This release of information applies to all applicable medical records, medical information, bodily fluid and tissue samples, and benefit payment information with respect to any illness, injury, medical history, consultation, prescription, treatment, or benefit, and copies of all applicable records thereof, which may be appropriate or necessary throughout the course of this Claim. This authorization shall specifically include, but shall not be limited to, medical records, medical information and benefit payment information pertaining or relating to the treatment of Acquired Immune Deficiency Syndrome, HIV, mental illness, and drug or alcohol related medical problems.

To comply with federal law, DO NOT include genetic testing or family medical history records.

The undersigned also authorizes the Social Security Administration and the Centers for Medicare & Medicaid Services (CMS), its agents and contractors, to release to Key Risk information concerning my workers compensation injury, entitlement dates and benefit amounts for my dependents and me.

The undersigned further authorizes Key Risk to release any such information as described above to its reinsurers, attorneys, second injury fund consultants, medical laboratories, medical peer review panels, CMS, state insurance or fraud agencies, managed care vendors, industry anti-fraud or law enforcement organizations, research and statistical reporting organizations, and the undersigned's employer and its excess insurer, to the extent that Key Risk considers doing so to be reasonably appropriate or necessary for purposes of its administration of the Claim or the insurance program under which the Claim has been made.

Information disclosed to Key Risk is from records whose confidentiality is protected by various state or federal laws. Any further disclosure of this information may no longer be subject to certain protections provided under federal privacy regulations. Unless revoked earlier by the undersigned, in writing, this authorization shall be valid for three years after Key Risk has closed the Claim. A copy of this authorization is to be considered as valid as the original.

Employee Signature: _____ Date: _____

Employee Name: _____ Employer: Sumner County Board of Education

Claim Number: _____ Date of Birth: _____

#2

Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
800-332-2667

FORM C-31

MEDICAL WAIVER AND CONSENT

This form is not required for injuries occurring on or after July 1, 2014

THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE BUREAU OF WORKERS' COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. § 50-6-204 AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

I,_____, having filed a claim for workers' compensation benefits, do hereby authorize
(Printed Patient Name)

_____ to furnish to my employer or my employer's
(Name of Medical Provider)

representative, and/or the Bureau of Workers' Compensation any information or written material reasonably related to my work-related injury of _____ for which I am claiming compensation. I further authorize the release of
(Date of Injury)

the same information to me or my attorney. 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.

A photocopy of the authorization may be accepted in lieu of the original.

_____ _____ _____
Patient Signature Date Date of Birth

Acknowledgement of Tennessee Workers Compensation Law

This Workers Compensation insurance applies to bodily injury by accident. It also applies to bodily injury by disease if it is caused or aggravated by the conditions of employment. The bodily injury must occur within the course and scope of employment and it must arise out of employment.

This insurance conforms to all parts of the Workers Compensation Law of the State of Tennessee, including benefits payable by this insurance and determination of compensability.

Some potential exceptions include but are not limited to:

- Failure to report the injury within 15 days of injury
- Authorized treating physician finds that injury is less than 50% work related
- Failing a post-accident drug and alcohol test
- Intentional self-inflicted injury
- Failure to use employer provided personal protective equipment
- Violation of safety protocols
- Idiopathic injury (the result of a purely personal condition or of an unknown cause)

Acknowledged by: _____

Date: _____

FORM C-42

TENNESSEE
BUREAU OF WORKERS' COMPENSATION

EMPLOYEE'S CHOICE OF PHYSICIAN
Medical Panel

Employer

- List at least three physicians and provide this panel to employee upon the report of a workplace injury.
- Keep the completed original form on file and send a copy to the employee for their records.
  - Do *not* send this form to the State unless requested.

Employee

- Fill out the bottom portion of this form to indicate which physician you choose.
  - If you refuse to accept medical services from the chosen physician, your rights may be delayed.
  - Traveling more than 15 miles (one way) to (or from) medical treatment? Employees may seek reimbursement of their travel expenses from the insurance carrier.
- **Send** completed form **back to your employer**.

TO BE COMPLETED BY THE **EMPLOYER** :

Employee Name: _____ Date Panel Provided: _____

Employer: Sumner County Board of Education Date of injury: _____

Employer Contact: Catrina Curd Phone: (615) 206-4035 Email: catrina.curd@sumnerschools.org

AFC Physicaian of Tennessee PC-
Urgent Care Clinic
291 Indian Lake Blvd
Hendersonville, TN 37075
615-265-5008

Concentra Medical Center
Urgent Care Clinic
1719 Gallatin Pike North
Gallatin, TN 37115
615-870-0143

Moore Life Urgent Care
Urgent Care Clinic
253 W Main Street
Gallatin, TN 37066
(615) 461-8784

Portland Family Care & Walk-In Clinic
Walk-In Clinic
421 N Broadway
Portland, TN 37148
615-323-1020

Crossroad Medical Group
Primary Care Physician
491 Sage Road N, Suite 800
White House, TN 37188
(615) 672-7122

CareNow Urgent Care
Urgent Care Clinic
1117 B Nashville Pike
Gallatin, TN 37066
(615) 989-9560

CareNow Urgent Care
Urgent Care Clinic
280 Indian Lake Blvd Ste 140
Hendersonville, TN 37075
615-590-1440

Fast Pace Health Urgent Care
Urgent Care Clinic
235 TN-52
Porrtland, TN 37148
(615) 802-1087

† = Denotes that the original provider record has been changed or a new record has been added.

(Optional) Telehealth-Only **Physician** name: MedCall Telemedicine Advisory Group, Chief Medical Office: Dr. John Peter McBryde Phone: Virtual MD + 1-866-687-0710

Telehealth Provider email address: info@medcalladvisors.com Web address: _____

This physician is a virtual physician licensed in your state. This selection will provide you with a prompt and real-time interactive evaluation by telephone or videoconference. A virtual physician is able to assess and diagnose, as well as provide referrals and prescribe medications when appropriate.

TO BE COMPLETED BY THE **EMPLOYEE:**

I have selected the following physician from the list provided to me by my employer:

Physician Name: _____ Appt Date/Time: _____

I select In-person treatment ☐ or Treatment by Telehealth ☐ Were you offered in-person treatment? ☐ Yes ☐ No

Employee Signature: _____ Date: _____

#5

Sumner County Board of Education

Scott Langford, Ed.D.
Director of Schools
695 East Main Street Gallatin, TN 37066-2472
Phone: (615) 451-5200 Fax: (615) 451-5216

Letter of Introduction to the Physician

Dear Provider:

An employee of, Sumner County Board of Education, has reported a possible work-related injury or illness. We have filed a worker's compensation claim with our carrier, Key Risk. Any authorization for treatment or referrals for additional treatment must be directed to Key Risk's claim call center at 866.847.8872.

Sumner County Board of Education requires that a post-accident drug test is administered in accordance with the Tennessee Drug Free Workplace Program.

Key Risk will be responsible for making all compensability decisions regarding this worker compensation claim. If the claim is compensable, all medical bills will be paid directly by Key Risk under
our workers compensation policy. Therefore, please forward all medical bills and medical reports (Note: bills cannot be processed without the appropriate supporting medical reports) directly to:

Key Risk
P.O. Box 14817
Lexington, KY 40512

The injured employee understands that if the claim is found not to be a compensable claim, he or she will be responsible for all bills related to your treatment.

We appreciate your cooperation and assistance. If you have any additional questions, please contact the Human Resources Department at 615.451.5207.

Sumner County Board of Education

Scott Langford, Ed.D.
Director of Schools
695 East Main Street Gallatin, TN 37066-2472
Phone: (615) 451-5200 Fax: (615) 451-5216

HOSPITAL STAFF

Sumner County Board of Education requires that a post-accident drug test is administered in accordance with the Tennessee Drug Free Workplace Program.

If an employee with the Sumner County Board of Education has reported a possible work-related injury or illness, please complete a drug screen. The Tennessee Drug Free Workplace Program to which we adhere now requires that a post-accident drug test be administered during treatment. All results and bills will go to our new carrier, Key Risk, listed below.

Key Risk
P.O. Box 14817
Lexington, KY 40512

We will file a worker's compensation claim with our carrier, Key Risk. Any additional treatment authorization or referrals must be directed to Key Risk's claim call center at 866.847.8872.

Key Risk will be responsible for making all compensability decisions regarding this worker compensation claim. If the claim is compensable, all medical bills will be paid directly by Key Risk under our worker's compensation policy. Therefore, please forward all medical bills and reports, drug test results directly to:

Key Risk
P.O. Box 14817
Lexington, KY 40512

We appreciate your cooperation and assistance. If you have any additional questions, please contact Key Risk at 1.866.847.8872 or the Sumner County Board of Education, Human Resources Department at 615.451.5207.

Key Risk
a Berkley Company

SmithRx
Pharmacy Benefits. Simplified.

Prescription Benefits Information For Your Workers' Compensation Claim

Welcome to SmithRx.

Your employer's workers compensation carrier has chosen SmithRx to provide pharmacy benefits for their injured workers. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy.

What do I need to do?

If you need a prescription filled for a work-related injury or illness, visit an in-network pharmacy and provide this card to the pharmacist. The pharmacist will fill your prescription at no cost to you.

May I fill prescriptions at my usual pharmacy?

Most pharmacies, including all major chains, are included in this network. To find or inquire about a network pharmacy and whether your preferred pharmacy is included, please call **(844) 414-0701**.

Is this my permanent card?

This card is valid for one-time use. You have 7 days from the date your injury was reported to utilize this card. If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Once you receive it, please use the permanent card going forward.

Your Temporary Pharmacy Benefits Card

Key Risk
a Berkley Company

SmithRx

Employer: Sumner County Board of Education

First Name: _____ Last Name: _____

Social Security Number: Please provide directly to Pharmacist

Date of Injury: _____

Note to Cardholder:
Present this card to the pharmacy to receive medication for your work related injury

SmithRx is the designated PBM for this patient

Note to Pharmacists:
ENTER RxBIN, RxPCN, and GROUP

MEMBER ID # FORMAT IS DATE OF INJURY AND SSN COMBINED AS FOLLOWS:
YYMMDD123456789

IF NO SSN, ALL 9s CAN BE USED

Pharmacist Support
844-414-0703

Rx Bin 019025
Rx PCN 8001002
Rx Group KRMFF

Note: Your use of this workers compensation pharmacy benefits card is limited to those prescriptions medically related to a workers compensation injury (covered under applicable state workers compensation regulations).

Questions? Call 844-414-0701

#8

Key Risk
a Berkley Company

Physician's Report / Pharmacy Guide

MAILING ADDRESS: P.O. Box 14817, Lexington, KY 40512
866.847.8872 www.keyrisk.com

EMPLOYER: Please complete the top section and give to the injured employee to take to his or her authorized treating physician. If you already have transitional duty job descriptions available, please attach a copy for the treating physician's review.

Name of Employee/Patient: **Last:** _____ **First:** _____

Date of Injury: _____

Name of Employer / Company: Sumner County Board of Education

Employer Signature: _____ Name of Doctor Chosen: _____

EMPLOYEE: Please take this form with you to an authorized treating physician. Please have the physician complete the middle section and return this immediately to your employer. The bottom section is for you to show the pharmacist should you need to have any prescriptions filled as prescribed by your authorized treating physician for this work related injury.

AUTHORIZED PHYSICIAN, PLEASE COMPLETE

Diagnosis: _____

A post accident drug test **has** been completed ☐ or ☐ **has not** been completed (check one)

In accordance with this patient's physical capability, check all that apply:

- ☐ May resume work immediately with no restrictions
- ☐ May resume work immediately with the following restrictions:
  - ☐ Sedentary work (sitting, occasional walking, standing, lifting less than 10 pounds)
  - ☐ Light work (lifting less than 20 pounds)
  - ☐ Medium work (lifting less than 50 pounds)
  - ☐ Heavy work (lifting less than 100 pounds)
  - ☐ Normal shift
  - ☐ Limited hours per day: ☐ 2 hours; ☐ 4 hours; ☐ 6 hours
  - ☐ Other: _____

☐ Repetitive Motion Restrictions (specific to hand/arm injuries):

Frequency	Left	Right	Both
No Use	☐	☐	☐
Occasional <33% of time	☐	☐	☐
Frequent 34-66% of time	☐	☐	☐
Regular 67-100% of time	☐	☐	☐

☐ Patient may return to work at full duty on (date): _____

☐ Patient has a return appointment on (date): _____ at (time) _____

Please indicate any referrals that are required: _____

_____ **Physician's Signature**

_____ **Date**

_____ **Physician's Name (type or print)**

_____ **Facility Name**

_____ **Facility Phone Number**

Contact Key Risk's Claim Department at 866.847.8872 for authorization for the referral.

PHARMACIST: Process all prescriptions through ***SmithRx*** for this patient. Contact ***SmithRx*** at (844) 414-0701 to establish eligibility. **DO NOT CHARGE THE PATIENT FOR THE PRESCRIPTION**

Albertsons	Duane Reade	H-E-B Grogery	Navarro Discount Pharmacy	Shoprite pharmacy
Bartell Drugs	Fairview Pharmacy	Henry Ford Medical Center	Pick N Save Pharmacy	Smith's Pharmacy
Bashas' United Drug	Food City Pharmacy	Homeland Pharmacy	Pillpack	Stop & Shop Pharmacy
Baylor Scott & White Pharmacy	Food Lion	Hy-Vee	Publix Super Market	Target
Bi-Mart Pharmacy	Fred Meyer Pharmacy	Ingles Markets	Quality Food Center	Thrifty Drug Store
Brookshire Pharmacy	Fred's Pharmacy	King Soopers Pharmacy	Ralphs Pharmacy	Tom Thumb Pharmacy
City Market	Fry's Food and Drug	Kinney Drugs	Recept Pharmacy	U Save It
Costco	Giant Eagle Pharmacy	Knight Drugs	Rite-Aid Pharmacy	Vons Pharmacy
Cub Pharmacy	Giant Pharmacy	Kroger	Safeyway Pharmacy	Walgreens
CVS Pharmacy	Hannaford Food and Drug	Maxor Pharmacy	Save Mart	Walmart
Diergerb Pharmacy	Harps Pharmacy	Medicap Pharmacy	Sav-Mor	Wegman Food Market
Dillon Pharmacy	Harveys Supermarket	Medicine Shoppe Pharmacy	Schnuck Market	Winn Dixie

SmithRx

Please call 844.414.0701 for additional participating pharmacies.

RMS 01.11.18TE

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