RIVCO HR workers' compensation

SUPERVISOR INJURY CHECK LIST

EMERGENCY IMMEDIATELY CALL:
911
SAFETY AT (951) 955-3520 OR AFTER HOURS AT (951) 313-9589
WORKERS' COMPENSATION DIVISION AT (951) 955-3530 or (951) 955-5864

EMPLOYEE SEEKING TREATMENT (ACUTE CARE - NON-EMERGENCY)

SUPERVISOR:

Call and report the injury to the intake line at **(888) 826-7835 and email to:** rcworkcompmail@rivco.org**.** Complete the Immediate Supervisor's Report of Employee Injury (Safety Form 674). Send the original to Safety Division, send a copy to the Workers' Compensation Division, and retain a copy for your records.

INVESTIGATE THE ACCIDENT AND ADDRESS THE PROBLEM.

- Correct any immediate hazards to prevent further injuries.
- Do NOT discard equipment or furnishings that caused injury.
- Remove the equipment from service.
- Tag the equipment for identification.
- Contact Safety **(951) 955-3520** for inspection, serious injuries, and hospitalizations.

PROVIDE EMPLOYEE WITH (6 items below):

☐ DWC-1 Employee Claim Form within **24 hours** of injury, if seeking treatment.

If unable to provide the DWC-1 in person, send to employee via **first class mail** within **24 hours** of injury.

- If not using a hardcopy of the DWC-1, print the DWC-1 in triplicate.
- Fill out bottom half of form. Leave #14 [date returned] blank. Employee to fill out top half of form.
- When DWC -1 is returned complete #14 [date Returned]
- Provide copy of the completed DWC-1, to the employee. Retain a copy for your records and send the original to Work Comp Division.

Medical Service Order (WC Form 5)
Employee Acknowledgement of the Medical Provider Network (MPN) (WC MPN Form 01)
Temporary Prescription Card (Rx Form 01)
Workers' Compensation Acknowledgement Form (WC Form 35)
Facts for Injured Workers (Rev. 10/26/17)

WORKERS' COMPENSATION ACKNOWLEDGEMENT FORM

REQUEST FOR MEDICAL TREATMENT

I am requesting medical care for my injury or illness which occurred on _____ (Date of Injury) and I have received the following:

- Workers' Compensation Claim Form (DWC-1)
- Medical Service Order (WC Form 5)
- Workers' Compensation Temporary Prescription Card (Rx Form 01)
- Employee Acknowledgement of the Medical Provider Network (WC MPN Form 01)

I UNDERSTAND it is my responsibility to fill out the Employee Claim Form (DWC-1) and return it to my employer. Failure to do so can affect my entitlement to Workers' Compensation benefits.

Initial here: _____

I UNDERSTAND that while I am receiving Salary Continuation, Temporary Disability Benefits, or Labor Code 4850 Benefits I am **REQUIRED** to report any earnings or income from any source to my claims adjuster, as it may affect my entitlement to benefits. Failure to disclose this information may result in prosecution for violation of the Workers' Compensation Fraud law, and, if convicted, may result in a felony.

Initial here: _____

I UNDERSTAND if I am offered a temporary modified or alternate work assignment it is my duty to show for the assignment and if I choose not to accept the assignment I **MAY NOT** be eligible for Salary Continuation, Temporary Disability Benefits, and or Labor Code 4850 Benefits.

Initial here: _____

Employee Signature: _____ Date: _____

Print Name: _____ SS#: _____

Department: _____ Employee Number: _____

Location: _____

Supervisor: _____ Date: _____

State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

County of Riverside Workers' Compensation Division
P.O. Box 1120, Riverside, CA 92502 Phone: (951) 955-3530 | Fax: (951) 955-3544

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME: County of Riverside

1a. Policy Number: N/A Permissably Self-Insured

2. MAILING ADDRESS: (Number, Street, City, Zip): P.O. Box 1120, Riverside, CA 92502

2a. Phone Number: (951) 955-3530

3. LOCATION if different from Mailing Address (Number, Street, City and Zip)

3a. Location Code

4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.: County Government

5. State unemployment insurance acct.no

6. TYPE OF EMPLOYER: ☐ Private ☐ State ☑ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)

8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM

9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM

10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)

11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No

12. DATE LAST WORKED (mm/dd/yy)

13. DATE RETURNED TO WORK (mm/dd/yy)

14. IF STILL OFF WORK, CHECK THIS BOX: ☐

15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No

16. SALARY BEING CONTINUED? ☐ Yes ☐ No

17. DATE OF EMPLOYER'S KNOWLEDGE / NOTICE OF INJURY/ILLNESS (mm/dd/yy)

18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)

19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning

20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)

20a. COUNTY

21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No

22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.

23. Other Workers injured or ill in this event? ☐ Yes ☐ No

24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold

25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.

26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY

27. Name and address of physician (number, street, city, zip)

27a. Phone Number

28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)

28a. Phone Number

29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.

Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME

31. SOCIAL SECURITY NUMBER

32. DATE OF BIRTH (mm/dd/yy)

33. HOME ADDRESS (Number, Street, City,Zip)

33a. PHONE NUMBER

34. SEX ☐ Male ☐ Female

35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)

36. DATE OF HIRE (mm/dd/yy)

37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours

37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal

37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED

38. GROSS WAGES/SALARY $_____ per _____

39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print)

Signature & Title

Date (mm/dd/yy)

Please do not use this column

CASE NUMBER

OWNERSHIP

INDUSTRY

OCCUPATION

SEX

AGE

DAILY HOURS

DAYS PER WEEK

WEEKLY HOURS

WEEKLY WAGE

COUNTY

NATURE OF INJURY

PART OF BODY

SOURCE

EVENT

SECONDARY SOURCE

EXTENT OF INJURY

• Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

PRINT

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IMMEDIATE SUPERVISOR'S REPORT OF EMPLOYEE INJURY
ACCIDENT INVESTIGATION

Injured Employee Information

Department:		Location Address:					
Injured Employee:		Job Title:		Employee #:		☐ M	☐ F
D.O.B.:		Date of Injury / Incident:		Time of Incident:		☐ am	☐ pm
Employee Work phone:		Work Status: ☐ Full Time ☐ Part Time ☐ Temporary… ☐ Intern ☐ Volunteer					
Date Reported:		Reported to:		Work Phone:			

Injury / Incident: (Please describe the injury/incident in detail below)

(Check all that apply) ☐ Injury ☐ Illness ☐ Near miss ☐ Treated on-site ☐ Urgent Care ☐ Hospitalized

Name Witnesses:		Work Phone:		Emp. ☐ Yes ☐ No
Name Witnesses:		Work Phone:		Emp. ☐ Yes ☐ No

Injured Body Part / Type of Injury

√	Body Part	R	L	√	Body Part	R	L
☐	Head				Torso		
☐	Face				Upper Back		
☐	Neck				Lowers Back		
☐	Eyes	☐	☐		Hips	☐	☐
☐	Shoulders	☐	☐		Thighs	☐	☐
☐	Upper Arms	☐	☐		Knees	☐	☐
☐	Elbows	☐	☐		Lower Legs	☐	☐
☐	Forearms	☐	☐		Ankles	☐	☐
☐	Wrists	☐	☐		Foot/Feet	☐	☐
☐	Hands	☐	☐		Toes	☐	☐
☐	Fingers	☐	☐		Other:	☐	☐

Type of injury: (Check most serious one)	
☐ Sprain	☐ Rash
☐ Strain	☐ Overexertion
☐ Puncture	☐ Dislocation
☐ Crushed	☐ Fracture
☐ Contusion	☐ Amputation
☐ Abrasion	☐ Whiplash
☐ Burn	☐ Other:

→ Type specific body part

What was employee doing prior to the incident? What equipment, tools or apparatus were being used?

What personal protective equipment was used (if any)?	

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IMMEDIATE SUPERVISOR'S REPORT OF EMPLOYEE INJURY
ACCIDENT INVESTIGATION

Nature of injury: (Check most serious one)

- ☐ Struck by
- ☐ Struck against
- ☐ Caught in / under / between
- ☐ Fall, same level
- ☐ Fall, different level
- ☐ Contact with chemical
- ☐ Contact with hot or cold surface
- ☐ Repetitive motion
- ☐ Foreign body in eye or skin
- ☐ Electrical shock
- ☐ Object being lifted or handled
- ☐ Contact with chemical
- ☐ Contact with hot or cold surface
- ☐ Inhalation, ingestion or absorption
- ☐ Vehicle accident
- ☐ Other:

Unsafe workplace conditions: (Check all that apply)

- ☐ Inadequate / unguarded hazard
- ☐ Uneven or obstructed walking surface
- ☐ Safety device is defective
- ☐ Leaving defective tool or equipment in service
- ☐ Workstation / area layout is hazardous
- ☐ Inadequate lighting
- ☐ Inadequate ventilation
- ☐ Required personal protective equipment not provided
- ☐ Lack of appropriate equipment / tools
- ☐ Improper clothing worn
- ☐ No training or insufficient training
- ☐ Other:

Unsafe acts by people: (Check all that apply)

- ☐ Operating without permission
- ☐ Operating at unsafe speed
- ☐ Servicing equipment that has power to it
- ☐ Making a safety device inoperative
- ☐ Using defective tool or equipment
- ☐ Using tool / equipment in an unapproved way
- ☐ Improper lifting or material handling technique
- ☐ Taking an awkward position or posture
- ☐ Distraction, teasing, horseplay, inattention
- ☐ Failure to wear / use required personal protective equipment
- ☐ Failure to use the appropriate equipment / tools for job
- ☐ Other:

Why did the unsafe conditions exist?

Why did the unsafe acts occur?

Why did the unsafe condition(s) exist?	☐ Y ☐ N	Why did the unsafe act(s) occur?	☐ Y ☐ N

How can future injuries / incidents be prevented?

Corrective Action Taken

Attachments: ☐ Yes ☐ No Totals to the right →	Written witness statements:	#	Photographs:	#	Maps / drawings:	#

Employee Signature _____ Date _____

Signature of Dept. Head _____ Date _____

Supervisor Signature _____ Date _____

Safety Coordinator _____ Date _____

Provide this form to an employee who is seeking treatment. The employee is to be provided with all four (4) pages of DWC-1. Send original to WC Division and maintain a copy for your records and provide copy to employee.

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it "**Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.*_____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.*_____ State. *Estado.*_____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).*_____ Time of Injury. *Hora en que ocurrió.*_____ a.m._____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. ☐ Check if you agree to receive notices about your claim by email only. ☐ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail._____ *Correo electrónico del empleado.*_____.
   You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

10. Name of employer. *Nombre del empleador.* County of Riverside
11. Address. *Dirección.* _____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.*_____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
    County of Riverside Workers' Compensation Division, PSI P.O. Box 1120 Riverside, CA 92502
16. Insurance Policy Number. *El número de la póliza de Seguro.* Permissably Self-Insured
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.*_____ 19. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/*Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility
Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Use the attached form to file a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If you file a claim, the claims administrator, who is responsible for handling your claim, must notify you within 14 days whether your claim is accepted or whether additional investigation is needed.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Do this right away to avoid problems with your claim. In some cases, benefits will not start until you inform your employer about your injury by filing a claim form. Describe your injury completely. Include every part of your body affected by the injury. If you mail the form to your employer, use first-class or certified mail. If you buy a return receipt, you will be able to prove that the claim form was mailed and when it was delivered. Within one working day after you file the claim form, your employer must complete the "Employer" section, give you a dated copy, keep one copy, and send one to the claims administrator.

Medical Care: Your claims administrator will pay for all reasonable and necessary medical care for your work injury or illness. Medical benefits are subject to approval and may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, medicines, equipment and travel costs. Your claims administrator will pay the costs of approved medical services directly so you should never see a bill. There are limits on chiropractic, physical therapy, and other occupational therapy visits.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness.

- If you previously designated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
- If your employer is using a medical provider network (MPN) or Health Care Organization (HCO), in most cases, you will be treated in the MPN or HCO unless you predesignated your personal physician or a medical group. An MPN is a group of health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
- If your employer is not using an MPN or HCO, in most cases, the claims administrator can choose the doctor who first treats you unless you predesignated your personal physician or a medical group.
- If your employer has not put up a poster describing your rights to workers' compensation, you may be able to be treated by your personal physician right after you are injured.

Within one working day after you file a claim form, your employer or the claims administrator must authorize up to $10,000 in treatment for your injury, consistent with the applicable treating guidelines until the claim is accepted or rejected. If the employer or claims administrator does not authorize treatment right away, talk to your supervisor, someone else in management, or the claims administrator. Ask for treatment to be authorized right now, while waiting for a decision on your claim. If the employer or claims administrator will not authorize treatment, use your own health insurance to get medical care. Your health insurer will seek reimbursement from the claims administrator. If you do not have health insurance, there are doctors, clinics or hospitals that will treat you without immediate payment. They will seek reimbursement from the claims administrator.

Switching to a Different Doctor as Your PTP:

- If you are being treated in a Medical Provider Network (MPN), you may switch to other doctors within the MPN after the first visit.
- If you are being treated in a Health Care Organization (HCO), you may switch at least one time to another doctor within the HCO. You may switch to a doctor outside the HCO 90 or 180 days after your injury is reported to your employer (depending on whether you are covered by employer-provided health insurance).
- If you are not being treated in an MPN or HCO and did not predesignate, you may switch to a new doctor one time during the first 30 days after your injury is reported to your employer. Contact the claims administrator to switch doctors. After 30 days, you may switch to a doctor of your choice if

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Utilice el formulario adjunto para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran dependiendo de la índole de su reclamo. Si usted presenta un reclamo, l administrador de reclamos, quien es responsable por el manejo de su reclamo, debe notificarle dentro de 14 días si se acepta su reclamo o si se necesita investigación adicional.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Haga esto de inmediato para evitar problemas con su reclamo. En algunos casos, los beneficios no se iniciarán hasta que usted le informe a su empleador acerca de su lesión mediante la presentación de un formulario de reclamo. Describa su lesión por completo. Incluya cada parte de su cuerpo afectada por la lesión. Si usted le envía por correo el formulario a su empleador, utilice primera clase o correo certificado. Si usted compra un acuse de recibo, usted podrá demostrar que el formulario de reclamo fue enviado por correo y cuando fue entregado. Dentro de un día laboral después de presentar el formulario de reclamo, su empleador debe completar la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos.

Atención Médica: Su administrador de reclamos pagará por toda la atención médica razonable y necesaria para su lesión o enfermedad relacionada con el trabajo. Los beneficios médicos están sujetos a la aprobación y pueden incluir tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio, las medicinas, equipos y gastos de viaje. Su administrador de reclamos pagará directamente los costos de los servicios médicos aprobados de manera que usted nunca verá una factura. Hay límites en terapia quiropráctica, física y otras visitas de terapia ocupacional.

El Médico Primario que le Atiende *(Primary Treating Physician- PTP)* es el médico con la responsabilidad total para tratar su lesión o enfermedad.

- Si usted designó previamente a su médico personal o a un grupo médico, usted podrá ver a su médico personal o grupo médico después de lesionarse.
- Si su empleador está utilizando una red de proveedores médicos (*Medical Provider Network- MPN)* o una Organización de Cuidado Médico *(Health Care Organization- HCO)*, en la mayoría de los casos, usted será tratado en la *MPN* o *HCO* a menos que usted hizo una designación previa de su médico personal o grupo médico. Una *MPN* es un grupo de proveedores de asistencia médica quien da tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una *HCO* o una *MPN*. Hable con su empleador para más información.
- Si su empleador no está utilizando una *MPN* o *HCO*, en la mayoría de los casos, el administrador de reclamos puede elegir el médico que lo atiende primero a menos de que usted hizo una designación previa de su médico personal o grupo médico.
- Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede ser tratado por su médico personal inmediatamente después de lesionarse.

Dentro de un día laboral después de que Ud. Presente un formulario de reclamo, su empleador o el administrador de reclamos debe autorizar hasta $10000 en tratamiento para su lesión, de acuerdo con las pautas de tratamiento aplicables, hasta que el reclamo sea aceptado o rechazado. Si el empleador o administrador de reclamos no autoriza el tratamiento de inmediato, hable con su supervisor, alguien más en la gerencia, o con el administrador de reclamos. Pida que el tratamiento sea autorizado ya mismo, mientras espera una decisión sobre su reclamo. Si el empleador o administrador de reclamos no autoriza el tratamiento, utilice su propio seguro médico para recibir atención médica. Su compañía de seguro médico buscará reembolso del administrador de reclamos. Si usted no tiene seguro médico, hay médicos, clínicas u hospitales que lo tratarán sin pago inmediato. Ellos buscarán reembolso del administrador de reclamos.

Cambiando a otro Médico Primario o *PTP*:

- Si usted está recibiendo tratamiento en una Red de Proveedores Médicos

your employer or the claims administrator has not created or selected an MPN.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Problems with Medical Care and Medical Reports: At some point during your claim, you might disagree with your PTP about what treatment is necessary. If this happens, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, the steps to take depend on whether you are receiving care in an MPN, HCO, or neither. For more information, see "Learn More About Workers' Compensation," below.

If the claims administrator denies treatment recommended by your PTP, you may request independent medical review (IMR) using the request form included with the claims administrator's written decision to deny treatment. The IMR process is similar to the group health IMR process, and takes approximately 40 (or fewer) days to arrive at a determination so that appropriate treatment can be given. Your attorney or your physician may assist you in the IMR process. IMR is not available to resolve disputes over matters other than the medical necessity of a particular treatment requested by your physician.

If you disagree with your PTP on matters other than treatment, such as the cause of your injury or how severe the injury is, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, notify the claims administrator in writing as soon as possible. In some cases, you risk losing the right to challenge your PTP's opinion unless you do this promptly. If you do not have an attorney, the claims administrator must send you instructions on how to be seen by a doctor called a qualified medical evaluator (QME) to help resolve the dispute. If you have an attorney, the claims administrator may try to reach agreement with your attorney on a doctor called an agreed medical evaluator (AME). If the claims administrator disagrees with your PTP on matters other than treatment, the claims administrator can require you to be seen by a QME or AME.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, you may receive temporary disability payments for a limited period. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Stay at Work or Return to Work: Being injured does not mean you must stop working. If you can continue working, you should. If not, it is important to go back to work with your current employer as soon as you are medically able. Studies show that the longer you are off work, the harder it is to get back to your original job and wages. While you are recovering, your PTP, your employer (supervisors or others in management), the claims administrator, and your attorney (if you have one) will work with you to decide how you will stay at work or return to work and what work you will do. Actively communicate with your PTP, your employer, and the claims administrator about the work you did before you were injured, your medical condition and the kinds of work you can do now, and the kinds of work that your employer could make available to you.

Payment for Permanent Disability: If a doctor says you have not recovered completely from your injury and you will always be limited in the work you can do, you may receive additional payments. The amount will depend on the type of injury, extent of impairment, your age, occupation, date of injury, and your wages before you were injured.

Supplemental Job Displacement Benefit (SJDB): If you were injured on or after 1/1/04, and your injury results in a permanent disability and your employer does not offer regular, modified, or alternative work, you may qualify for a nontransferable voucher payable for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law.

Death Benefits: If the injury or illness causes death, payments may be made to a

(Medical Provider Network- MPN), usted puede cambiar a otros médicos dentro de la MPN después de la primera visita.

- Si usted está recibiendo tratamiento en un Organización de Cuidado Médico (Healthcare Organization- HCO), es posible cambiar al menos una vez a otro médico dentro de la HCO. Usted puede cambiar a un médico fuera de la HCO 90 o 180 días después de que su lesión es reportada a su empleador (dependiendo de si usted está cubierto por un seguro médico proporcionado por su empleador).
- Si usted no está recibiendo tratamiento en una MPN o HCO y no hizo una designación previa, usted puede cambiar a un nuevo médico una vez durante los primeros 30 días después de que su lesión es reportada a su empleador. Póngase en contacto con el administrador de reclamos para cambiar de médico. Después de 30 días, puede cambiar a un médico de su elección si su empleador o el administrador de reclamos no ha creado o seleccionado una MPN.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes serán revelados. Si usted solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Problemas con la Atención Médica y los Informes Médicos: En algún momento durante su reclamo, podría estar en desacuerdo con su *PTP* sobre qué tratamiento es necesario. Si esto sucede, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, los pasos a seguir dependen de si usted está recibiendo atención en una *MPN*, *HCO* o ninguna de las dos. Para más información, consulte la sección "Aprenda Más Sobre la Compensación de Trabajadores," a continuación.

Si el administrador de reclamos niega el tratamiento recomendado por su *PTP*, puede solicitar una revisión médica independiente *(Independent Medical Review-IMR)*, utilizando el formulario de solicitud que se incluye con la decisión por escrito del administrador de reclamos negando el tratamiento. El proceso de la *IMR* es parecido al proceso de la *IMR* de un seguro médico colectivo, y tarda aproximadamente 40 (o menos) días para llegar a una determinación de manera que se pueda dar un tratamiento apropiado. Su abogado o su médico le pueden ayudar en el proceso de la *IMR*. La *IMR* no está disponible para resolver disputas sobre cuestiones aparte de la necesidad médica de un tratamiento particular solicitado por su médico.

Si no está de acuerdo con su *PTP* en cuestiones aparte del tratamiento, como la causa de su lesión o la gravedad de la lesión, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, notifique al administrador de reclamos por escrito tan pronto como sea posible. En algunos casos, usted arriesg perder el derecho a objetar a la opinión de su *PTP* a menos que hace esto de inmediato. Si usted no tiene un abogado, el administrador de reclamos debe enviarle instrucciones para ser evaluado por un médico llamado un evaluador médico calificado *(Qualified Medical Evaluator-QME)* para ayudar a resolver la disputa. Si usted tiene un abogado, el administrador de reclamos puede tratar de llegar a un acuerdo con su abogado sobre un médico llamado un evaluador médico acordado *(Agreed Medical Evaluator- AME)*. Si el administrador de reclamos no está de acuerdo con su *PTP* sobre asuntos aparte del tratamiento, el administrador de reclamos puede exigirle que sea atendido por un *QME* o *AME*.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. puede recibir pagos por incapacidad temporal por un periodo limitado. Estos pagos pueden cambiar o parar cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no puede trabajar durante más de 14 días.

Permanezca en el Trabajo o Regreso al Trabajo: Estar lesionado no significa que usted debe dejar de trabajar. Si usted puede seguir trabajando, usted debe hacerlo. Si no es así, es importante regresar a trabajar con su empleador actual tan

spouse and other relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Resolving Problems or Disputes: You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your employer or claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) or unemployment insurance (UI) benefits. Call the state Employment Development Department at (800) 480-3287 or (866) 333-4606, or go to their website atwww.edd.ca.gov.

You Can Contact an Information & Assistance (I&A) Officer: State I&A officers answer questions, help injured workers, provide forms, and help resolve problems. Some I&A officers hold workshops for injured workers. To obtain important information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an I&A officer of the state Division of Workers' Compensation. You can also hear recorded information and a list of local I&A offices by calling (800) 736-7401.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their website at **www.californiaspecialist.org**.

Learn More About Workers' Compensation: For more information about the workers' compensation claims process, go to www.dwc.ca.gov. At the website, you can access a useful booklet, "Workers' Compensation in California: A Guidebook for Injured Workers." You can also contact an Information & Assistance Officer (above), or hear recorded information by calling 1-800-736-7401.

pronto como usted pueda medicamente hacerlo. Los estudios demuestran que entre más tiempo esté fuera del trabajo, más difícil es regresar a su trabajo original y a sus salarios. Mientras se está recuperando, su *PTP*, su empleador (supervisores u otras personas en la gerencia), el administrador de reclamos, y su abogado (si tiene uno) trabajarán con usted para decidir cómo va a permanecer en el trabajo o regresar al trabajo y qué trabajo hará. Comuníquese de manera activa con su *PTP*, su empleador y el administrador de reclamos sobre el trabajo que hizo antes de lesionarse, su condición médica y los tipos de trabajo que usted puede hacer ahora y los tipos de trabajo que su empleador podría poner a su disposición.

Pago por Incapacidad Permanente: Si un médico dice que no se ha recuperado completamente de su lesión y siempre será limitado en el trabajo que puede hacer, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, grado de deterioro, su edad, ocupación, fecha de la lesión y sus salarios antes de lesionarse.

Beneficio Suplementario por Desplazamiento de Trabajo *(Supplemental Job Displacement Benefit- SJDB)*: Si Ud. se lesionó en o después del 1/1/04, y su lesión resulta en una incapacidad permanente y su empleador no ofrece un trabajo regular, modificado, o alternativo, usted podría cumplir los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo un curso de reentrenamiento y/o mejorar su habilidad. Si Ud. cumple los requisios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a un cónyuge y otros parientes o a las personas que viven en el hogar que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad laboral, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (Código Laboral, sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Resolviendo problemas o disputas: Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su empleador o administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatalde Incapacidad *(State Disability Insurance- SDI)* o beneficios del desempleo *(Unemployment Insurance- UI)*. Llame al Departamento del Desarrollo del Empleo estatal al (800) 480-3287 o (866) 333-4606, o visite su página Web en www.edd.ca.gov.

Puede Contactar a un Oficial de Información y Asistencia *(Information & Assistance- I&A)*: Los Oficiales de Información y Asistencia *(I&A)* estatal contestan preguntas, ayudan a los trabajadores lesionados, proporcionan formularios y ayudan a resolver problemas. Algunos oficiales de *I&A* tienen talleres para trabajadores lesionados. Para obtener información importante sobre el proceso de la compensación de trabajadores y sus derechos y obligaciones, vaya a www.dwc.ca.gov o comuníquese con un oficial de información y asistencia de la División Estatal de Compensación de Trabajadores. También puede escuchar información grabada y una lista de las oficinas de *I&A* locales llamando al (800) 736-7401.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, o consulte su página Web en www.californiaspecialist.org.

Aprenda Más Sobre la Compensación de Trabajadores: Para obtener más información sobre el proceso de reclamos del programa de compensación de trabajadores, vaya a www.dwc.ca.gov. En la página Web, podrá acceder a un folleto útil, "Compensación del Trabajador de California: Una Guía para Trabajadores Lesionados." También puede contactar a un oficial de Información y Asistencia (arriba), o escuchar información grabada llamando al 1-800-736-7401.

INDUSTRIAL INJURY MEDICAL SERVICE ORDER

To Physician: _____

Address: _____

Please call the office listed below prior to and after rendering medical treatment to the following employee in accordance with the terms of the Workers' Compensation Laws. Complete and mail and or fax the Doctor's First Report (5021) of Occupational Injury and Illness to the address listed below.

Phone: (951) 955-3530
County of Riverside, Workers' Comp. Division

Please serve your treatment requests on the required Request for Authorization for Medical Treatment (RFA) with the supporting medical report to our Utilization Review Department at:

Fax: (951) 955-0876
Email: WCURFax@rivco.org
County of Riverside, Workers' Comp. Division
PO Box 1120,
Riverside, CA 92502

Pursuant to 8 CCR 9792.6.1(t)(3) County of Riverside designates the above fax, email and PO Box as the proper method of service for all Requests for Authorization. Service on any other fax, email or PO Box will not be considered proper service triggering the provisions of Labor Code 4610.

SERVICE OF MEDICAL REPORTING AND BILLING

Please send your bills and reports to:

Fax: 888-851-9190
Email: 8888519190@onlinecapturecenter.com
CorVel Corporation
PO Box 6966
Portland, OR 97228

Employee Signature: _____ Date _____

Print Name: _____ SS#: _____

Occupation: _____ Employee Number: _____

Department: _____ Supervisor: _____ Date: _____

EMPLOYEE ACKNOWLEDGEMENT OF THE MEDICAL PROVIDER NETWORK

In order to provide the most timely and suitable quality medical care in the event of an injury on the job, the County of Riverside has instituted a Medical Provider Network for Workers' Compensation.

The following procedures must be followed for all work related injuries and illnesses.

- Report promptly any work related injury to the supervisor.
- For a referral to a medical provider specialist, contact your Supervisor, Manager, or Claims Adjuster.
- Ensure all medical treatment is handled only through the MPN (Medical Provider Network) unless otherwise authorized.
- Direct all questions about the level of care to the PCP (Primary Care Physician), who is the focal point for all medical treatment.
- A directory of medical care providers is available at my request through the Workers' Compensation Division.

Please sign below to indicate that you have read and understand the procedures to follow in the event of an injury and your duties under our Medical Provider Network.

Print Name	Date
	County of Riverside
Employee Signature	Employer
Employee Number	

A COPY OF THE MPN DIRECTORY IS AVAILABLE FROM YOUR EMPLOYER OR ADJUSTER UPON YOUR REQUEST.

RECONOCIMIENTO DEL EMPLEADO DE LA MEDICAL PROVIDER NETWORK

Para brindar atención médica de la más rápida y de apropiada calidad en el evento de una lesión ocasionada en el trabajo, hemos instituido una Red de Proveedores Médicos para Compensación Laboral.

Los procedimientos siguientes deben ser seguidos para todas las lesiones y enfermedades ocasionadas en el trabajo.

- Reporte inmediatamente a su supervisor cualquier lesión ocasionada en el trabajo.
- Para una referencia a un médico especialista, comuníquese con su empleador o ajustador de reclamos.
- Cerciórese que todo tratamiento médico sea manejado únicamente por la MPN (Red de Proveedores Médicos), a menos que de otro modo autorizado
- Dirija toda pregunta sobre el nivel de cuidado al PCP (Primary Care Physician – Médico de Cabecera), quien es el punto de referencia para todo tratamiento médico.
- Un directorio de proveedores de cuidado médico está disponible al solicitarlo a través de mi empleador.

Por favor firmar abajo para indicar que usted ha leído y entendido los procedimientos que se siguen en el evento de una lesión y sus responsabilidades bajo nuestra Red de Proveedores Médicos.

Nombre en Imprenta	Fecha
	County of Riverside
Firma del Empleado	Empleador County of Riverside
Número del Empleado	

UNA COPIA DEL DIRECTORIO DE LA MPN ESTA DISPONIBLE DE SU EMPLEADOR O AJUSTADOR AL SOLICITARLO.

RIVCO 1HR
workers' compensation

INFORMATION REGARDING RIVERSIDE COUNTY'S
MEDICAL PROVIDER NETWORK

The County of Riverside's Medical Provider Network (MPN) is the exclusive source for medical treatment, unless you have a valid pre-designated physician, for work-related injuries or illnesses. The County's MPN is approved by the State of California and managed by CorVel. It is comprised of multispecialty physicians and specialists, all to assist you while you are recovering from your injury. The MPN also includes, Kaiser Occupational Clinics in Riverside and Fontana. Primary treating providers are available within 15 miles or 30 minutes and specialty care providers are within 30 miles or 60 minutes from your work or residence.

You may change your medical provider after your first visit; however, unless you have a valid pre-designated physician, you must treat with a medical provider within the MPN and you must notify your claims adjuster of the change. To find a medical provider within the MPN you may search the MPN website. The website provides multiple search options, i.e., zip code, city, specialty, etc.

To access the Medical Provider Network (MPN) go to https://www.corvel.com/ppo-lookup/

Once on the MPN webpage, you will need to enter the Login and Network below.

LOGIN: CORMPN
NETWORK: County of Riverside MPN

If you have questions or are unable to get an appointment within 3 days for primary treatment or 20 days for specialty treatment or need assistance call (951) 955-3530 or (951) 955-5864 or you may call your claims adjuster directly. In addition, you may call the MPN assistance line at (855) 857-7556 or email them at MPNAccess_Hotline@CorVel.com.

EMERGENCY CARE For emergency care, call 911 or go to the nearest healthcare provider regardless of whether they are an MPN participant. If your injury is work-related, advise the emergency care provider to contact the County of Riverside's Workers' Compensation Division at (951) 955-3530 or (951) 955-5864 to arrange the transfer of your care to an MPN provider when medically appropriate.

Initial and Ongoing Treatment: For non-emergency situations, we will assist you in getting initial treatment from an MPN provider within 3 business days. After your initial visit, you may change your treating physician at any time, if your claim is not delayed; however, you **MUST** select another physician within the MPN and notify your claims adjuster.

Treatment authorization: For accepted claims, an MPN physician or valid predesignated physician, may provide medical treatment, durable medical equipment and tests, within state guidelines, without prior authorization, within 30 days of the date of injury or illness.

To obtain authorization for all other treatment, your primary treating physician should fax a Request for Authorization (RFA) to **(951) 955-0876,** call the claims adjuster, or call Utilization Review department at **(951) 955-0862**.

APPEAL OF non-certifications: If your treatment is non-certified, you may request an Independent Medical Review (IMR) by following the Appeal instructions included with the non-certification notice. Please note, the IMR to Appeal Utilization Review decisions is **NOT** the same as the IMR process discussed below.

Second opinion, Third Opinion and INDEPENDENT MEDICAL REVIEW: If you disagree with the diagnosis or treatment plan determined by your treating physician, and would like a second or third opinion, you must take the following steps:

1. Notify your claims adjuster and submit an objection in writing to the County of Riverside, Workers' Compensation Division at, P. O. Box 1120, Riverside, CA 92502-1120.
2. We send you a list of MPN physicians
3. Select a physician from the list and schedule an appointment within 60 days of receiving the list. If you fail to schedule an appointment within 60 days your right to seek another opinion will be waived.
4. Notify your claims adjuster of your selection and the date and time of your appointment so we can ensure your medical records are sent to the second opinion physician in advance of your appointment.
5. To request a third opinion follow the same process for requesting a second opinion.
6. If you select a third opinion you will also be provided with information and a request form for an Independent Medical Review (IMR).

If the second or third opinion physician doesn't believe they are able to address the disputed issue, the physician's office will notify us and we will send you another list for you to make another selection.

If the second or third opinion physician agrees with your need for a treatment or test, you may be allowed to receive that recommended treatment or test from a provider inside or outside the MPN, including the second or third opinion physician.

INDEPENDENT MEDICAL REVIEW (IMR): If you disagree with the third opinion physician you must notify your claims adjuster and submit an objection in writing to the County of Riverside, Workers' Compensation Division at, P. O. Box 1120, Riverside, CA 92502-1120. You will be provided with a form to be filed with the Administrative Director for an Independent Medical Review.

If the second opinion, third opinion or IMR agrees with your treating doctor, you will need to continue to receive medical treatment within the MPN if the MPN contains a physician who can provide the recommended treatment.

If the IMR does not agree with your treating MPN physician, you will be allowed to receive the recommended medical treatment from a provider inside or outside of the MPN. Any physician chosen outside of the MPN must be within reasonable geographic area. The treatment or diagnostic test is limited to the recommendation of the MPN/IMR.

Terminated MPN Providers and Continuity of Care - If your physician terminates from the MPN, the County of Riverside's Workers' Compensation Division will advise you on your options for continued treatment. In some instances, the terminated physician may continue to treat you through the County of Riverside's Workers' Compensation Division's Continuity of Care plan. Copies of the plan are available upon request.

SEARCH THE MEDICAL PROVIDER NETWORK

WEBSITE: **https://www.corvel.com/ppo-lookup/**
LOGIN: CORMPN
NETWORK: COUNTY OF RIVERSIDE MPN

If you have questions or are unable to get an appointment within **3 days** for primary treatment or **20 days** for specialty treatment or need assistance call **(951) 955-3530** or **(951) 955-5864** or you may call your claims adjuster directly. In addition, you may call the MPN assistance line at **(855) 857-7556** or email them at **MPNAccess_Hotline@CorVel.com.**

Workers' Compensation Temporary Prescription ID Card

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 800.945.5951.

Atencion Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 800.945.5951.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at 888.786.9640.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control A4

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

(enter in DOI field in the format YYYYMMDD)

Express Scripts

ID #: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____
MM/DD/YYYY

Group #: L4BA

Employee Date of Birth: _____
MM/DD/YYYY

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

County of Riverside

EXPRESS SCRIPTS®

Rx Form 01

Participating Retail Network Pharmacies

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare Neighborcare Network Pharmaceuticals Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

NOTE: This form is not valid in the state of Ohio. For all other states, liability of a workers' compensation claim is not assumed based on the dispensing of medication(s) to a patient.

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RIVCO 1HR
workers' compensation

FACTS FOR INJURED WORKERS

WHAT IS WORKERS' COMPENSATION?

A safe working environment is important to the County of Riverside. However, should you become injured or ill due to your employment with the County we want ensure you receive prompt quality medical treatment. Workers' compensation benefits are to provide employees who sustain an injury or illness on the job with benefits to medically cure or relieve them of their industrial injury.

Benefits include: medical treatment, temporary disability benefits, permanent disability benefits, return to work benefits, and in the case of a death, benefits to qualified dependents.

COUNTY OF RIVERSIDE WORKERS' COMPENSATION PROGRAM:
The County of Riverside is self-insured and self- administered. This means:

- The County of Riverside's workers' compensation benefits are directly paid out of the County's budgets rather than an insurance carrier.
- The workers' compensation claims are managed by certified County employees.

WHEN AM I COVERED?

Coverage under workers' compensation begins when you arrive at work. If you are injured or sustain an illness that arose in the course and scope of employment your injury is covered.

Some injuries that result from voluntary activity, such as off duty social or athletic activities may not be covered.

Generally, volunteers are not covered; however, there may be some exceptions to this rule.

HOW DO I GET BENEFITS?

IMMEDIATELY notify your supervisor if you sustain work related injury or illness so you can get the medical treatment you need without delay.

Benefits do not start until you notify your employer. Failure to timely report your injury may result in benefits being delayed and possibly denied.

If your injury or illness is greater than first-aid, your supervisor will provide you with a claim form (DWC-1). To submit a claim, complete the "Employee" section of the DWC-1 and mark the "Temporary Receipt" box, keep a copy and return the form to your supervisor to complete the "Employer" section. After the form is completed your supervisor will provide you with a completed copy and send a copy to the County's Workers' Compensation Department.

California law requires medical treatment to be authorized within one working day of receipt of your DWC-1. If your claim is delayed for any reason, you will be entitled to medical treatment up to $10,000 pending a decision to accept or reject your claim.

BENEFITS OVERVIEW:

There are five basic benefits provided through workers' compensation: medical treatment, temporary disability benefits, permanent disability benefits, supplemental job displacement benefits and in the case of an employee's death, death benefits.

EMERGENCY MEDICAL CARE:

If you are injured and need emergency medical care, go to the nearest emergency room. If you cannot get yourself to the emergency room, call 911 immediately and report your injury to your employer as soon as possible.

MEDICAL TREATMENT:

Workers' Compensation provides treatment that is reasonably necessary to cure or relieve you from the effects of the industrial injury or illness. There is no deductible or co-payment and is at no cost to you. You will be reimbursed mileage to and from your medical appointments.

California law prohibits an injured worker from being billed for treatment related to a claimed workers' compensation injury or illness. If you receive a bill from a medical provider regarding your claim notify your workers' compensation adjuster.

MEDICAL PROVIDER NETWORK PROGRAM:

The County of Riverside uses an approved Medical Provider Network [MPN] as it is the exclusive source to provide medical care.

To access the County of Riverside's MPN go to: http://www.corvel.com/ppo-lookup

LOGIN: CORMPN
NETWORK: COUNTY OF RIVERSIDE MPN

If your claim is accepted, or while in a delayed status, you are required to treat within the County's MPN regardless of union representation, unless your personal care physician was pre-designated prior to your injury.

Once you report your injury to your supervisor you will be referred for medical treatment within the MPN. After this first visit you are free to change to any other physician in the MPN if you prefer another physician or location. Let your adjuster know of any changes.

THE RIGHT TO PRE-DESIGNATE YOUR PERSONAL TREATING PHYSICIAN:

You have the right to pre-designate your personal treating physician to treat you in the event of an industrial injury or illness. For the physician to be eligible, prior to your industrial injury or illness, you must complete the requisite pre-designation form and the physician must have agreed and signed the requisite forms.

PHARMACY CARD:

When you file your claim, you will be provided with a temporary prescription ID card from Express Scripts, followed by a permanent card. Use this card to fill your authorized workers' compensation prescriptions at participating chain pharmacies at no cost to you.

UTILIZATION REVIEW:

When your primary treating physician makes a recommendation for treatment he or she must submit a request for authorization (RFA).

Within 5 working days a notice of authorization, modification, or delay will be issued. If the RFA is delayed a final determination will be issued no more than 14 calendar days from the receipt of the initial request.

To assist in your recovery, if your physician advises you of a treatment recommendation notify your claims adjuster so he or she can contact the physician for the treatment request, as the request may not always be sent to the adjuster right away.

If there is any dispute over treatment, you can appeal the decision either to the County's program or to an Independent Medical Reviewer assigned by the State.

INDEPENDENT MEDICAL REVIEWER (IMR):

The State of California created an Independent Medical Reviewer as a way for employees to appeal any determinations made by utilization review regarding their treatment. Should your treatment be denied or modified, you will be provided instructions and forms with the utilization review determination along with instructions on how to request an IMR.

RETURN TO WORK PROGRAM:

During the recovery period, if you are unable to return to your regular job, you may be provided with appropriate modified or alternate employment. This is a 90-day program, monitored by your treating physician.

WAGE CONTINUATION:

Although not a regular benefit under workers' compensation, the County does offer wage continuation in cases where you cannot return to work due to your injury. The length of this benefit varies based upon your union affiliation.

TEMPORARY DISABILITY BENEFITS:

This benefit is tax free and based on two-thirds of your average weekly earnings with minimum and maximum rates set by the state and based on your date of injury and is paid out every two weeks.

For injuries on or after 04/19/2004, Temporary Disability benefits are limited to 104 weeks, and may be extended up to 240 weeks in certain circumstances. These benefits normally continue until you are either released from care or returned to work.

TO BE ELIGIBLE FOR TEMPORARY DISABILITY BENEFITS:

- Your claim must be accepted
- Your disability must be certified by the physician treating you for your workers' compensation claim AND the physician must be in the MPN or a valid pre-designated physician.
- You must be declared temporarily totally disabled or provided with work restrictions that cannot be accommodated by your employer

<u>If you are provided with an offer of temporary modified duty and you chose not to accept you may not be eligible for Temporary Disability benefits.</u>

PERMANENT DISABILITY:

Once your physician determines your condition has reached maximum medical improvement your physician will issue a final report. The final report will address, if applicable, the need for future medical care and any permanent impairment you may have sustained.

QUALIFIED MEDICAL EVALUATIONS:

If you disagree with the findings of your physician, you have the right to request an additional evaluation from a state Qualified Medical Evaluator. The evaluation is free to you and will be paid by the County.

SUPPLEMENTAL JOB DISPLACEMENT BENEFITS [SJDB]:

If you are unable to return to work with the County of Riverside because of your work-related injury or illness, you may be entitled to a Supplemental Job Displacement Benefit [SJDB] voucher. The voucher is to assist with retraining or skill enhancement. This voucher can be used for schooling, counseling and supplies to train for a new occupation.

DEATH BENEFITS:

Qualified dependents will be awarded benefits set forth by the Workers' Compensation Appeals Board.

Up to $10,000 to cover funeral costs.

DELAYED CLAIMS:

In the event, additional information is needed to make a determination regarding your claim, your adjuster, by law, has a duty to investigate and by law has up to 90 days and conduct an investigation.

Failure to cooperate with the investigation may result in your claim being denied. If your claim is not denied within the 90 days, it is presumed to be compensable.

While your claim is delayed, you will be entitled to medical treatment up to $10,000 pending a decision to accept or reject your claim.

ATTORNEYS:

It is not necessary to be represented by an attorney to receive these benefits. However, you do have the right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits.

The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

ADDITIONAL RESOURCES:

The State also offers an Information and Assistance Officer free of charge to help you in answering questions or filling out forms should there be any problems with your case. The Riverside Information and Assistance Officer can be reached at 951-782-4347 or you may receive recorded information by calling 1-800-736-7401. You can also visit the State's website at: www.dwc.ca.gov.

DISCRIMINATION:

It is a violation of Labor Code section 132(a) and illegal for your employer to terminate or punish you for filing a workers' compensation claim or testifying in another person's workers' compensation claim. Discrimination can result in increased benefits and reimbursement of lost wages and or benefits.

DISABILITY LEAVE NOTICE

It is also important that you read the following notice regarding your County Employment:

Regardless of whether your illness/injury is work-related or non-work-related, all County employees who are on leave from work must be on an approved leave of absence. Failure to apply for a leave of absence in a timely manner could jeopardize your County employment status.

Leave of Absence and Family/Medical Leave request forms can be obtained from your Department Representative or from the HR Toolbox tab on www.workforceexchange.net. For additional information, contact your Department Representative or Human Resources Services Team.

WORKERS' COMPENSATION FRAUD IS A FELONY

Anyone who makes or causes to be made any knowingly false or fraudulent material statement for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony. **Fines can be up to $150,000 and imprisonment up to 5 years**.

County of Riverside Workers' Compensation Division
P.O. Box 1120
Riverside CA 92502

FOR MORE INFORMATION VISIT: http://workcomp.rc-hr.com
PHONE: (951) 955-3530
Email: rcworkcompmail@rivco.org