Workers Compensation Injury Form

Type or write clearly and submit to the Personnel office immediately
Personnel office: (615) 264-5314

Employee Name: _____ Dept: _____

Job Title: _____ Employment Status ☐ Full Time ☐ Part Time

Date of Hire: _____ Wage: _____

Date of Injury: _____ Time Employee Began Work on Injury Date: _____ ☐ AM ☐ PM

Time of Injury: _____ ☐ AM ☐ PM Was Employee Transported by Ambulance: ☐ YES ☐ NO

Who did you report the injury to immediately? _____

Address where injury occurred: _____

Body Part Affected:

☐ Head
☐ Neck
☐ Upper Extremities
☐ Trunk
☐ Lower Extremities
☐ Multiple Body Parts
☐ Fatal
☐ Unclassified / Unknown

Employee Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Personal Phone #: _____

Date of Birth: _____ SS#: _____

Marital Status

☐ Common Law Married
☐ Divorced
☐ Legally Separated
☐ Married
☐ Registered Domestic Partner
☐ Single
☐ Separated
☐ Unmarried
☐ Widow/Widower

Please provide Emergency Contact information below for injured employee.

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

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:

Medical Treatment

☐ I refuse medical treatment at this time.

- The City reserves the right to require medical/fit-for-duty evaluation(s) if felt it is in the best interest of the City.

☐ I wish to seek medical treatment from the following Workers Comp provider:

☐ AFC ☐ CareNow ☐ Vanderbilt ☐ Hendersonville Emergency Room ☐ Other: _____

- Workers Comp providers are listed on the next page.
- Hendersonville Medical Center ER should only be used in true emergencies or after Urgent Cares are closed.

Injured Employee Signature: _____ **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, signed version of this 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 to benefits 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 City of Hendersonville Date of Injury _____

Employer Contact Amanda Grider or Jason Gallo Phone (615) 264-5314 Email hr@hvilletn.org

Physician Option 1 Name Vanderbilt Walk-in Clinic - Dr. Claude Shackelford Phone (615) 875-1000

Address 128 Anderson Lane N. City Hendersonville State TN Zip _____

Is Telehealth available? Yes ☐ No ☑ If yes, web address _____

Physician Option 2 Name CareNow Urgent Care - Dr. Todd Wise Phone (615) 590-1440

Address 280 Indian Lake Blvd City Hendersonville State TN Zip 37075

Is Telehealth available? Yes ☐ No ☑ If yes, web address _____

Physician Option 3 Name American Family Care - Dr. Ben Barlow Phone (615) 265-5008

Address 291 Indian Lake Blvd City Hendersonville State TN Zip 37075

Is Telehealth available? Yes ☑ No ☐ If yes, web address www.afcurgentcare.com/telecare

(Optional) Telehealth-Only **Physician 4** Name N/A Phone _____

Telehealth Provider email address _____ Web address _____

TO BE COMPLETED BY THE **EMPLOYEE:**

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

Physician Name _____

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

Employee Signature _____ Date _____

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...

TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below. *Please note this First Fill card is valid for 10 days from initial use. However, if your claim is accepted and set up with Public Entity Partners, you will need to process your prescriptions using your permanent pharmacy card, even if it is within that 10 day period.*

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-940-4459 or visit www.tmesys.com.

If you have any questions or need assistance, please contact or have the pharmacy contact Optum at:

1-866-940-4459

OPTUM® PUBLIC ENTITY PARTNERS

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Public Entity Partners Workers' Compensation Program
CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-866-940-4459

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	PEPFF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-247_PEPFF

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación. *Tenga en cuenta que esta tarjeta First Fill es válida por 10 días desde su primer uso. Sin embargo, si su reclamación es aceptada y registrada por Public Entity Partners, deberá procesar sus recetas médicas utilizando su tarjeta farmacéutica permanente, incluso si es dentro de ese periodo de 10 días.*

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias y todas las grandes cadenas de farmacias forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-940-4459 o visite www.tmesys.com.

Si tiene alguna pregunta o necesita ayuda, comuníquese o haga que la farmacia se comunique con Optum al:

1-866-940-4459

OPTUM® PUBLIC ENTITY PARTNERS

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Public Entity Partners Workers Compensation Program

PORTADORA EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist

NUMERO DE SEGURO SOCIAL FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-866-940-4459

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	PEPFF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-247_PEPFF

CITY OF HENDERSONVILLE
Vanderbilt Workers Compensation Authorization

Vanderbilt Walk-In Clinic
128 Anderson Lane N.
Hendersonville, TN 37075
VUMC Supervising Physician: Dr. Claude Shackelford
Walk-In Clinic Manager: Bobby Gipson, 615-875-6114

Employee Name_____ Date_____

Job Position_____

Date of Incident_____ Time of Incident _____ ☐AM ☐PM

What Was Injured_____ Left / Right (if applicable)

Was This Reported to Your Supervisor: Yes No

Note: We cannot perform drug testing that requires a chain of command for employment or legal purposes.

City of Hendersonville Human Resources:
Attn: HR Manager: Amanda Grider
Phone Number: (615) 590-4605
Email: agrider@hvilletn.org
Fax Number: (615) 264-5353

City of Hendersonville Workers Compensation Carrier:
Company: Public Entity Partners
Address: 562 Franklin Rd Ste #200 Franklin, TN 37069
Phone Number: (615) 371-0049

CareNow Urgent Care

Work CompTreatment Authorization Form

For Employer Paid Service, go to next page
Employee must present authorization form and government issued Photo ID at time of service.

Account Code: 1374

Patient Info

First and Last Name:	Job Title:
SS#:	DOB:

Employer Info

Company Name: City of Hendersonville		Authorized by Name (DER): Amanda Grider	
Phone: 615-590-4605	Fax: 615-264-5353	E-mail: agrider@hvilletn.org	
Address: 101 Maple Drive N.		City: Hendersonville	State: TN / Zip: 37075

Work-Related Injury

Claim Number:	Date of Injury:	Body Part(s) Authorized to Evaluate/Treat:

Insurance Carrier Name: Public Entity Partners	Assigned Adjuster Name: TBD
Insurance Carrier Phone: 615-371-0049	Direct Phone:
Insurance Carrier Fax:	Email:

Is a **post-accident** drug screen and/or breath alcohol test required? (Check all that apply):

☐ **No Post-Accident Testing Required** **eScreen Acct #:** _____

☐ DOT Breath Alcohol Test ☐ Non DOT Breath Alcohol Test

Drug **Rapid:** ☐ 5-Panel ☐ 10-Panel

Drug **Standard:** ☐ 5-Panel ☐ 10-Panel ☐ DOT Drug Screen ☐ Other Panel

Reason: ☑ Post-Accident **Authorized By:** ☑ Employer ☐ Insurance Carrier

EMPLOYER AUTHORIZATION:
I authorize CareNow® Urgent Care to provide work related accident services and understand that my company (listed above) will be financially responsible for all services rendered to the patient (listed above).

Amanda Grider	Amanda Grider	
Employer Representative (Print Name)	Employer Representative Signature	Date

Please contact our occupational medicine department to add or change services at **CareNowOccMed@HCAhealthcare.com**

Scan here for clinic hours and to find a location, or go to **CareNow.com**

☐ **CLINIC USE ONLY:** VERBAL AUTHORIZATION RECEIVED BY THE ABOVE LISTED EMPLOYER REPRESENTATIVE

CareNow Employee (Print Name)	CareNow Employee Initials	CareNow Location	Date

IndianLake@AmericanFamilyCare.com

Employer Authorization for Examination or Treatment

Please email or fax this and all completed forms to the clinic listed above.

Patient's Name _____ Date _____

EMPLOYER REPRESENTATIVE

Please complete all information in this section before sending employee for treatment or services.

Employer Name: City of Hendersonville
Employer Address: 101 Maple Drive N
City, State, Zip: Hendersonville, TN 37075
Employer Contact Name: Amanda Grider
Employer Contact Phone: 615-590-4605
Employer Contact Fax:

☐ Bill to Company/Employer
☑ Workers' Comp Carrier

WORKERS' COMP CARRIER

WC Carrier Name: Public Entity Partners
Address: 562 Franklin Rd. Ste 200
Phone: 615-371-0049 Fax:
City/State/Zip: Franklin, TN 37069

AUTHORIZED SERVICES

AFC is authorized to provide the following services:

PHYSICALS

- ☐ Return to Work
- ☐ Basic Physical
- ☐ Annual Physical
- ☐ DOT Physical
- ☐ DOT Recertification
- ☐ Hazmat
- ☐ Return to Work

REASON FOR DRUG SCREEN

- ☐ Pre-Employment
- ☐ Random
- ☐ Return to Work
- ☐ Follow-Up
- ☐ Reasonable Suspicion
- ☐ Periodic Review
- ☐ Post Accident

DRUG AND ALCOHOL

DOT	NON-DOT
☐ Breath Alcohol	☐ In-House Rapid: ( )5 Pan ( )10 Pan
☐ AFC CCF- V5k.DOT1.	☐ AFC CCF- V5K.NON1.
☐ Empoyer CCF	☐ Employer CCF
	☐ Breath Alcohol
	☐ Hair
	☐ Blood Alcohol

OTHER SERVICES

- ☐ Spirometry (Pulmonary Function)
- ☐ Audiometry (Hearing Test)
- ☐ Snellen (Vision Exam)
- ☐ Ishihara (Color Blind Test) EKG
- ☐ Work Comp Injury Treatment X
- ☐ OSHA Respirator Questionnaire Review
- ☐ Chest XRay One View

LAB SERVICES

- ☐ PPD/Tuberculosis Skin Test - 1st Step
- ☐ PPD/Tuberculosis Skin Test - 2nd Step
- ☐ Vaccine - Hepatitis A - 1st Injection
- ☐ Vaccine - Hepatitis A - 2nd (180 days)
- ☐ Vaccine - Hepatitis B - 1st
- ☐ Vaccine - Hepatitis B - 2nd (30 days)
- ☐ Vaccine - Hepatitis B - 3rd (180 days)
- ☐ Other Vaccine

Specify:

- ☐ Titer - Hepatitis A (send to lab)
- ☐ Titer - Hepatitis B (send to lab)
- ☐ Titer - Hepatitis B (send to lab)
- ☐ Tetanus - Tdap
- ☐ Tetanus - TD
- ☐ Post Exposure Protocol
- ☐ Covid Instant Testing - X
- ☐ Covid Lab Test

Signature of Employer _____ Date _____