HAMBLEN COUNTY SCHOOLS NOTICE OF ACCIDENT OR INCIDENT
*****FOR EMPLOYEES, VISITORS, OR VOLUNTEERS*****

INSTRUCTIONS FOR COMPLETING REPORT:

1. **Except for #15, this form should be completed in its entirety BY THE PRINCIPAL or immediate supervisor** and submitted to the personnel office within 24 hours of the incident (faxes to 586-7760 are acceptable).
2. **Other than signatures, please print all information.**
3. **Principal signature REQUIRED for school incidents.**
4. **Injured party signature required for EMPLOYEE injury.**

INDIVIDUAL IDENTIFICATION:

1. Injured party's relationship to Hamblen County Schools: ☐ Employee ☐ Visitor ☐ Volunteer
2. Date of incident_____ 3. Time_____
4. Full name of injured party_____
5. Street address_____
6. City/State/Zip_____
7. Home phone_____ 8. Work phone_____
9. Social Security number_____ 10. Date of birth_____
11. Position (employee injury only)_____
12. School where incident occurred_____
13. Immediate supervisor signature_____ Date_____
14. Principal signature_____ Date_____

ACCIDENT / INCIDENT INFORMATION:

15. **(TO BE COMPLETED BY INJURED PARTY)** Please provide details of the incident._____

_____

_____

_____

What were you doing immediartely prior to the accident?_____

_____

What part(s) of the body was injured?_____

What specifically caused the injury? (If it was fall, what caused you to fall?) _____

_____

_____

_____ Principal to initial_____

16. Were there any witnesses?_____ If yes, provide names, addresses, phone numbers.

_____

17. Did loss of property occur?_____ If yes, describe the loss to the best of your ability.

18. Did the incident involve a slip, trip, or fall?_____

19. Did the incident involve lifting?_____ If yes, indicate approximate weight of material being lifted and how it was lifted. _____

20. Was the injured party performing regular job duties at the time of the incident?_____

21. Is this type of work performed on a regular basis?_____

22. Did injury occur?_____ If yes, indicate portion of the body that was injured.

Type of injury (cut, sprain, exposure, bruise, burn, etc.)_____

23. If injury occurred, is the injury an aggravation of an old injury?_____

24. If injury occurred, did it appear immediately?_____

25. Did a physician treat injured party?_____ If yes, date of treatment_____

Name of physician_____

26. Did injured party go to hospital?_____ If yes, date(s) of hospitalization_____

27. Did injured party miss work?_____ If yes, date(s) missed_____

AUTHORIZATION AND SIGNATURE

I certify that the information set forth above is true and accurate to the best of my knowledge. By signing this form, I authorize any person(s) who did or who may hereafter provide medical attention, examination, or treatment, or who may possess information or knowledge that may be used to render a decision in my claim for injury, to disclose such information or knowledge to the Hamblen County Schools and/or any other agency contracted by the Hamblen County Schools to investigate this health claim.

Injured party (printed name)_____

Injured party (signature)_____

Submit to personnel office within 24 hours of accident or incident. Date received in personnel office_____

FORM C-42G TENNESSEE DIVISION OF WORKERS' COMPENSATION
Nashville, Tennessee 37243-1002
Website: www.tn.gov/labor-wfd/wcomp.html
Telephone: 1-800-332-2667

EMPLOYEE'S CHOICE OF PHYSICIAN

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.

THIS FORM IS ONLY FOR USE BY GOVERNMENTAL ENTITIES ESTABLISHED BY TCA§29-20-401 AND SELF INSURED POOLS ESTABLISHED BY TCA§50-6-405(c)(1).

State File Number: _____ Date of Injury: _____

Employee Name: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: Hamblen County Board of Education / LGWCF FEIN: 62-6000633

Address: 210 East Morris Blvd. City: Morristown State: TN Zip: 37813

PANEL OF PHYSICIANS

Tennessee Code Annotated §50-6-204 requires an employer to offer a panel of three physicians to the injured employee. The injured employee must select a physician from the panel.

Physicians Name: Dr. F. Edward "Ward" Phillips/Phillips Healthcare Group
Phone: 423-839-2120 Address: 6890 West A.J. Hwy. City: Talbott State: TN Zip: 37877
Is Physician a Specialist? ☐ Yes ☒ No If yes, give specialty: Ortho, Neuro, etc.

Physicians Name: Dr. Devon D. Smith/Primary Care Associates
Phone: 423-581-7040 Address: 204 Shaver Drive City: Talbott State: TN Zip: 37877
Is Physician a Specialist? ☐ Yes ☒ No If yes, give specialty: Ortho, Neuro, etc.

Physicians Name: Dr. Frederick R. Yarid/Hamblen Family Medicine
Phone: 423-587-9777 Address: 823 McFarland Street City: Morristown State: TN Zip: 37814
Is Physician a Specialist? ☐ Yes ☒ No If yes, give specialty: Ortho, Neuro, etc.

Physicians Name: Dr. Jackie Livesay/MHHS Emergency Room
Phone: 423-492-9000 Address: 908 West 4th North Street City: Morristown State: TN Zip: 37814
Is Physician a Specialist? ☐ Yes ☒ No If yes, give specialty: Ortho, Neuro, etc.

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

Physician Chosen:

Employee Signature:_____ Date Selected:_____

A copy of this form must be provided to the employee. The employer must keep the original form on file and upon request provide a copy to the Division of Workers' Compensation.

This form is required to be in compliance with Tennessee Code Annotated §50-6-204. LB-0382 (rev. 8/16)

Submit to personnel office within 24 hours of accident or incident. Date received in personnel office _____.

The provider should photocopy this document while returning the original to the employee for use with all providers.

Your Workers' Compensation Claim Ticket

This document shall act as your Identification Card for your workers' compensation insurance coverage. ***It is important to present this document upon arrival to any medical provider that is treating you for your work related illness or injury.*** If you have any questions regarding your workers compensation coverage or seeking care from a medical provider please contact adjuster listed below.

EMPLOYEE INFORMATION

Alternative Service Concepts
Loyalty • Integrity • Flexibility • Expertise

LGIP Local Government Insurance Pool
serving Tennessee Counties and County Agencies since 1981

Patient's Name: _____

Participant: Hamblen County Board of Education

Account Name: The Local Government Work Comp Fund

Date Of Injury: _____/_____/_____

Claim #:

Part of Body: Contact WC Adjuster

THIS CLAIM TICKET DOES NOT CERTIFY COMPENSABILITY OR GUARANTEE PAYMENT

EMPLOYEE RIGHTS AND RESPONSIBILITIES

You have the right to seek medical treatment from a medical provider of your choice listed below.

Facility	Address	City	St.	Zip	Phone
Dr. F. Edward Phillips/ Phillips Healthcare Group	6890 West A.J. Hwy	Talbott	TN	37877	423-839-2120
Dr. Devon Smith/ Primary Care Associates	204 Shaver Drive	Talbott	TN	37877	423-581-7040
Dr. Frederick R. Varid Hamblen Family Medicine	823 McFarland St	Morristown	TN	37814	423-587-9777
Dr. Jackie Livesay/ MHHS Emergency Room	908 W. 4th North St	Morristown	TN	37814	423-492-9000

Should there be need for a referral to another physician or specialty care you must contact the adjuster for prior authorization.

CONTACT HUMAN RESOURCES

Jessica Darnell or Lindsey Reel at 423-585-3711 or 423-586-7700

It is your responsibility to notify both your supervisor and/or handling adjuster of any change in your work status. You should always obtain a work status report from your treating doctor after every office visit.

EMPLOYER INFORMATION

SUPERVISOR

If employee is severely injured call 911 for ambulance transportation to the nearest emergency center.

You are responsible for making sure that your employee presented a claim ticket in order to obtain the necessary treatment.

Take a copy of this claim ticket with you to the clinic.
You are responsible for completing the first report of injury within 24 hours of notice of the injury. (Regardless whether the employee receives medical treatment or not.)

PROVIDER INFORMATION

Please note that all inquiries concerning the compensability of a claim or questions concerning the payment of any billings should be directed to the handling adjuster.

Claims Contact Information

- Medical Only Adjuster Karla Bailey
  Phone: 615-360-1389 Fax: 615-360-5698
- WC Claims Adjuster Linda Whitley
  Phone: 615-360-1375 Fax: 615-360-5698
- Claims Supervisor Tina Lee
  Phone: 615-360-1379 Fax: 615-360-5698
- Claim Manager Karen Baskin
  Phone: 615-360-5685 Fax: 615-360-5698

Claim Ticket Valid for Date of Injury and Body Part Only

PRECERT INFORMATION

Contact CareWorks at 1-800-322-1276 for all requests for precertification including nurse case manager.

BILL REVIEW

Questions concerning Bill review should be directed to Michael Hopkins at CareWorks at 615-515-2415.

PROVIDER BILL SUBMISSION

All bills should be submitted to the following address:
CareWorks
Attn: Alternative Service Concepts
2000 Mallory Lane, Suite 130-601
Franklin, TN 37067

DIAGNOSTIC STUDIES

Scheduling Services provided by : One Call Medical: 1-800-872-2875.

DURABLE MEDICAL EQUIPMENT INFORMATION

Scheduling Services provided by MSC: 1-800-848-1989.

PHARMACY INFORMATION

Please note all national pharmacies are participants in the prescription drug program.

Prescription Drug Card

Mitchell ScriptAdvisor

Temporary Prescription Benefit Card
Please contact Mitchell ScriptAdvisor at 1-866-846-9279 for the Member ID #

Member Name:
Member ID #:
Rx BIN: 019082
PCN: MPS

mitchell

URGENT CARE CLINIC HOURS

Phillips Healthcare Group:
Sick clinic hours; M-F 7:45-8:00 AM, 12:30-12:45 PM & 4:00-4:30 PM
Primary Care Associates:
Sick clinic hours; M-F 7:45-8:00 AM & 12:30-12:45 PM