ENCOVA INJURY KIT SUPERVISOR CHECKLIST

- [ ] Secure proper medical care for your employee and inform them if modified/light duty work is available.

- [ ] Follow your company's procedure to report the injury. If you are not aware of the procedure, call your supervisor.

- [ ] Give this envelope to your employee and ensure they complete the enclosed forms.

- [ ] Report the injury to Encova within 24 hours using one of the following methods:

  - **Internet:** File electronically through Encova Edge; contact your agent or Encova's Customer Service Unit for information about becoming an Encova Edge user
  - **Phone:** Call 866-452-7425, select "policyholder" and option 1 (This is the quickest and most convenient option)
  - **Email:** Send an email with the completed First Report of Injury as an attachment to claimsintake@encova.com; visit the specific jurisdiction's website to obtain the First Report of Injury form
  - **Fax:** Send the completed First Report of Injury to 877-293-5513 or 304-941-1151; visit the specific jurisdiction's website to obtain the First Report of Injury form

If you have an Encova Edge account, you can click the Virtual Claims Kit link, choose the appropriate carrier and jurisdiction and locate the correct form.

INJURED EMPLOYEE CHECKLIST

- [ ] Report all injuries to supervisor

  (Alabama, Georgia, Indiana, Iowa, Kansas, Missouri, North Carolina, Pennsylvania, South Carolina, Tennessee and Virginia allow your employer to either choose your physician or provide you with a list of approved physicians)

- [ ] Obtain either a full-duty release or a completed Physician Statement of Physical Capabilities Form from the doctor (if released for light/modified duty)

- [ ] If released to return to work, return on your next scheduled work day with either your full-duty release or the Physician Statement of Physical Capabilities Form

- [ ] If not released to return to work, you must call your supervisor within one business day and provide:
  - Physician's name, address and phone number
  - Date of your next scheduled doctor appointment

- [ ] Return Incident Report to your supervisor upon return or within 24 hours

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Mitchell ScriptAdvisor

Workers' Compensation *FIRST FILL* – Temporary Prescription Card

Mitchell ScriptAdvisor has been selected by **Encova Insurance** to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply **present it at the pharmacy** at the time your prescription is filled. This form should ensure that you will have NO out-of-pocket expenses when you fill your first prescription. Please Note: This is a temporary prescription card, you may receive a permanent drug card in the future.

For your convenience, Mitchell ScriptAdvisor has an extensive network of retail pharmacies including major chain drug stores. For pharmacy locations, you may call our toll-free number at 866.846.9279 or visit our website at www.mitchellscriptadvisor.com to access the pharmacy locator.

Employee

- You may contact Mitchell Customer Service at (866) 846-9279 or you may present this sheet to the pharmacist along with your prescription.

Pharmacy

- This sheet is a Temporary Prescription ID Card for a 10 Days' Supply Fill until this individual's permanent card can be provided.
- Create the ID number based off the criteria provided and write it, along with individual's name, on the ID card below.
- All data needed to process this script through the Script Care Adjudication System is included in the drug card represented below.

Mitchell ScriptAdvisor

Temporary Prescription Benefit Card

SCRIPT CARE, LTD.

Attention Pharmacists: **Process through Script Care and Enter RxBIN, RxPCN and GROUP.**

Member Name:

Member ID #:

Date of Injury + Date of Birth (Example: MMDDYYMMDDYY)

Rx BIN:	019082
PCN:	MPS
Group:	MPS001536TC

Walmart · RITE AID · Longs Drugs · CVS pharmacy · TARGET · Walgreens · SAFEWAY

Questions?
Contact us at 866.846.9279

mitchell

Mitchell International
866.221.6588

This card is to be used for prescriptions related to your workers' compensation injury covered under the workers' compensation insurance policy. Use of this card does not waive any limitations or exclusions for the policy. This card does not confirm coverage. To confirm eligibility or obtain specific information, please contact the Help Desk with the information from the front of this card.

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MEDICAL RECORDS RELEASE

TO: Any licensed physician, chiropractor, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of my health, history, condition or well-being.

In accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state privacy laws and regulations, I, _____ (Claimant name), _____ (Claim number) hereby authorize the use or disclosure of my individually identifiable health information described below to _____ (Company name), **P.O. Box 3151 Charleston, WV 25322.**

For purposes of this Authorization, individually identifiable health information shall mean: Any and all of my personal health information created, received or obtained, including any medical or dental records, x- ray or radiology films, pathology materials, MedFlight reports, insurance-related documents and benefit forms, or any other medically-related record or item that relates to my physical health or condition, the provision of health care to me, or the payment for my care, as the foregoing information relates to the assessment, treatment, or recordation of history related to any injury to me or any disease that affects me regardless of the time or cause of the onset of said injury or disease.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, psychological or psychiatric treatment, social services counseling, communicable diseases or infections, tuberculosis and hepatitis. Such records will be released through this authorization unless otherwise indicated. **Do not release any of the following information if an "x" appears before the description.**

_____ HIV/AIDS	_____ Behavioral health	_____ Drug and alcohol	_____ Genetic history

I further authorize Recipient to use, disclose or re-disclose any and all of my above-described health information and to make copies thereof for purposes of evaluating and administrating an insurance claim I have filed with Recipient. I understand that my health information may be re-disclosed by Recipient and may then no longer be protected by any applicable federal or state privacy laws or regulations.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Recipient at the address listed above. I understand that my revocation will only be effective after it is received by Recipient and that the revocation will not apply to information that has already been released in response to this authorization.

This authorization shall expire on _____. If no date is specified, this authorization shall expire one year from the date it is signed. Any disclosures made prior to my revocation or prior to the expiration of this authorization will not be affected by my revocation or by the expiration of this authorization.

I understand and agree that a photocopy or electronically reproduced copy of the original of this authorization shall have the same effect as an original.

_____ Signature of individual

_____ Date

_____ Social Security number

_____ Date of birth

_____ Signature of personal representative, estate representative or guardian.

(Provide documentation of authority to act for individual.)

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CLAIM FILING FORM

(Compatible with Encova Edge claim filing and OSHA Form 301 filing)

** Denotes required field*

Please note: The fields highlighted in grey are pre-populated in the online system.

Date of injury: *	Policy number:	Policy name:	Case # from OSHA Log (if applicable):
Filing date:	Claim type: * ☐ Incident ☐ Indemnity ☐ Medical only		Jurisdiction:

POLICY / DEMOGRAPHIC QUESTIONS

What is your name? *		What is your job title?		
What is your telephone number? *	What is your fax number?	What is your email address?		
Are you the contact for this claim? ☐ No ☐ Yes		If no, who should we contact for additional information?		
What is the contact's phone number?		What is the contact's email?		
Is this a Federal Longshore (USL&H) claim? ☐ No ☐ Yes		Are you reporting a fatality? ☐ No ☐ Yes		Date of death: *
Date of injury/date of last exposure: *		What is your policy number? *		
What is the employee's ID type? *	☐ Employment Visa number ☐ Green Card number ☐ Passport number ☐ Social Security number	ID number: *		
What is the employee's name?	First: *	MI:	Last: *	Suffix:
What is the employee's mailing address? Street/P.O. Box: *				
Zip: *	City: *	State: *	Country:	
What is the employee's physical address? Street/P.O. Box:				
Zip:	City:	State:	Country:	
What is the employee's primary telephone number?		What is the employee's alternate telephone number?		
What is the employee's regular work schedule?				

DEMOGRAPHIC / WAGE QUESTIONS

What is the employee's date of birth? *			Gender: * ☐ Male ☐ Female ☐ Unknown			
Marital status: * ☐ Married	☐ Single	☐ Divorced	☐ Widowed	☐ Separated	☐ Common law	☐ Unknown
What is the industrial code? *			What is the job title? *			
Description of employee's job and regular duties:						

DEMOGRAPHIC / WAGE QUESTIONS

What is the employee's hire date? *	What is the state of hire for this employee?
Employment type: ☐ Full-Time ☐ Part-Time ☐ Volunteer	Is the employee: An officer? ☐ No ☐ Yes An owner/part owner? ☐ No ☐ Yes
What is the hourly rate of pay for this employee?	What are the number of hours worked per week for this employee?

What is the daily rate of pay for this employee?	How many hours per day did the employee work?	How many days per week did the employee work?

Is there any additional wage information not included in the daily rate (i.e. commissions, etc.)?

Is the employee continuing to receive full wages? ☐ No ☐ Yes

INJURY QUESTIONS

What is the primary work location? *
Name:

Address: *		Country:
Zip: *	City: *	State: *

What is the reporting location?

Did the accident occur on the employer's property? * ☐ No ☐ Yes

If no, where did the accident occur? * Name: *		Address:	
Zip:	City:	State:	Country:

Was this the employee's regular department? ☐ No ☐ Yes	In what department did the accident occur?
Was injury the result of a motor vehicle accident? ☐ No ☐ Yes	Was any equipment involved in the injury? ☐ No ☐ Yes If yes, what equipment?

What was the employee doing just before the incident occurred?

How did the accident occur? *

What object or substance directly harmed the employee?

Was safety equipment provided? ☐ No ☐ Yes	Was safety equipment used? ☐ No ☐ Yes

If yes, what type?

What was the injured body part(s)? *

What is the body part location? * ☐ Bilateral ☐ Left ☐ Lower ☐ Middle ☐ Right ☐ Upper ☐ Not applicable

What is the nature of the injury (sprain, strain, etc.)? *

What was the cause of injury? *

Are you aware of a previous injury to this body part? * ☐ No ☐ Yes
If yes, please explain: *

Do you have knowledge of pre-existing disability, industrial or non-industrial? ☐ No ☐ Yes
If yes, please explain: *

Are there outside activities or medical conditions that would affect this injury? ☐ No ☐ Yes
If yes, please explain: *

INJURY QUESTIONS

List all **others** involved in the accident with contact information:

1.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
2.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
3.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			

List all **witnesses** to the accident (or enter "none"):

1.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
2.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
3.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			

RETURN-TO-WORK QUESTIONS

What time did the employee begin work? * (Include a.m. or p.m.)	
What time did the accident occur? * (Include a.m. or p.m.)	Who was notified of the accident?
When did the injured worker notify the employer? * (Date)	Did the claimant stop work? ☐ No ☐ Yes
What is the loss type? ☐ Incident only ☐ Indemnity ☐ Medical only ☐ Modified duty with no wage loss ☐ Modified duty with wage loss	
What was the last date worked?	What time did the employee stop work? (Include a.m. or p.m.)
Has the employee returned to work? ☐ No ☐ Yes	Date of return to work?
Did/will the claimant return to full duty? ☐ No ☐ Yes	Do you have transitional/modified work available? ☐ No ☐ Yes
Number of hours per week?	Modified daily rate of pay?

MEDICAL QUESTIONS

Was medical treatment provided? ☐ No ☐ Yes		Name of medical provider:	
Medical facility/provider's address:			
Zip:	City:	State:	Country:
Was employee treated in an emergency room? ☐ No ☐ Yes		Was employee hospitalized overnight as an in-patient? ☐ No ☐ Yes	
What was the method of transportation? ☐ Helicopter ☐ Ambulance ☐ Personal vehicle ☐ Other			
Do you require your employees to be drug tested? ☐ No ☐ Yes		If yes, when was the employee last tested?	
Was an incident report completed? * ☐ No ☐ Yes		Do you have any reason to question this injury? * ☐ No ☐ Yes	
Do you have any comments for the record?			

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PHYSICIAN STATEMENT OF PHYSICAL CAPABILITIES

Return completed form to:
Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151
Or fax to: 877-898-6980

Claimant name	Claimant number	Date of injury

Please complete this form after your examination of the patient. Indicate the patient's capabilities, including work hours, duties, environmental factors and any other information pertinent to this employee's recovery and early return to work.

Medical diagnosis

Please indicate the extent to which the employee can perform the following work postures and work activities during the usual workday.

Standing	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Sitting	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Walking	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Climbing	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Kneeling	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
	>67% of workday	34% - 66% of workday	6% - 33% of workday	<5% of workday	0% of workday

Please indicate the extent to which the employee can perform the following:
(C - Constantly = greater than 67% F - Frequently = 34% to 66% O - Occasionally = 6% to 33% R - Rarely = Less than 5% N - Never = 0%)

Lifting/carrying	C	F	O	R	N
5 lbs. or less					
5–10 lbs.					
11–20 lbs.					
21–40 lbs.					
41–60 lbs.					
61–100 lbs.					
100+ lbs.					
Activity					
Bend					
Squat					
Twist/turn					
Crawl					
Reach above shoulder					
Type/keyboard					
Joystick/ hand controls					
Vibration					

Pushing/pulling	C	F	O	R	N
5 lbs. or less					
5–10 lbs.					
11–20 lbs.					
21–40 lbs.					
41–60 lbs.					
61–100 lbs.					
100+ lbs.					
Driving					
Automatic drive					
Standard drive					

Upper extremities	Yes		No	
Simple grasping	☐ Right	☐ Left	☐ Right	☐ Left
Pushing/pulling	☐ Right	☐ Left	☐ Right	☐ Left

Operate foot controls	Yes		No	
	☐ Right	☐ Left	☐ Right	☐ Left
Simultaneous	☐ Yes		☐ No	

Comments

Physician name	Physician telephone
Date released with above restrictions	Date released for full-duty work
Projected date for MMI	Date and time of next appointment
Physician signature	Date

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WEST VIRGINIA WORKERS' COMPENSATION EMPLOYEES' AND PHYSICIAN'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

For Encova use only
Claim number:
Team assigned:

SECTION I - EMPLOYEE'S CLAIM INFORMATION

1. Last name	First name		MI
2. Address			3. Telephone
City	State	ZIP	4. Social Security number
5. Date of birth	6. Sex ☐ M ☐ F		7. Marital status
8. Date of injury or last exposure	Time ☐ a.m. ☐ p.m.		9. Time you began work on date of injury ☐ a.m. ☐ p.m.
10. Date you stopped working due to injury			
11. Have you retired? ☐ Yes ☐ No	If "yes," what was the date you retired?		
12. Employer's name		Supervisor's name	
Address			
City	State	ZIP	Telephone
13. Job title/description			
14. Body parts injured			
15. Describe how your injury occurred (specify the cause, what you were doing and equipment/objects involved):			
16. Did injury occur on employer's property? ☐ Yes ☐ No Address where injury occurred			
17. Please identify any witnesses to your injury			

I certify that the above is true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I hereby authorize any physician, chiropractor, surgeon, practitioner or other health care provider, any hospital, including Veterans' Administration or governmental hospital, and medical service organization, any insurance company, any law enforcement or military agency, any government benefit agency including the Social Security Administration, or any other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to the diagnosis, treatment and/or counseling for HIV/AIDS, psychological conditions and/or alcohol or substance abuse, for which I must give specific authorization. A Photostat of this authorization shall be valid as the original.

Employee's signature Date

SECTION II - ALL INFORMATION MUST BE COMPLETED BY INITIAL PROVIDER

1. Name of physician/hospital		2. FEIN/Social Security number	
3. Address			
City	State	ZIP	Telephone
4. Date of initial treatment		5. Date patient may return to work	
6. Have you advised the patient to remain off work four or more days? ☐ Yes If yes, indicate dates from to ☐ No If no, is the patient capable of ☐ Full duty ☐ Modified duty If the patient is capable of returning to modified duty, specify any limitations/restrictions			
7. Condition is a direct result of ☐ Occupational injury? ☐ Occupational disease? ☐ Non-occupational condition?			
8. Did this injury aggravate a prior injury/disease? ☐ Yes ☐ No		If "yes," explain	
9. Description of injury or occupational disease			
10. Body part(s) injured		11. ICD10-CM diagnosis code(s) in order of severity	
12. Name of physician referred to		13. If the patient was hospitalized, where?	

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge I have been informed of my responsibilities under West Virginia Workers' Compensation Law and agree to abide by such in the administration of services provided thereunder. I understand the submission of false statements or billing may result in prosecution under state and federal law. I further agree to release any office notes/test results immediately to the employer or their representative.

Physician's signature Date

General instructions for completing the "BI-1,"

"West Virginia Workers' Compensation Employees' and Physician's Report of Occupational Injury or Disease"

Please read carefully.

BI-1, West Virginia Workers' Compensation Employees' and Physician's Report of Occupational Injury or Disease: To be completed by the claimant and the medical provider.

This form should not be used to file occupational pneumoconiosis or hearing loss claims.

To the claimant: Section I of this form must be completed by you. **When you have completed this form, make a copy for your records and give a copy to your employer.** The initial medical provider is responsible for completing Section II of this form. If you do not receive a decision on your claim within **14 days** after submitting the form, contact Encova Insurance. To be eligible for benefits, **a claim must be filed with Encova within six months** from and after the injury or death. If you have any questions, contact Encova at 866-452-7425 or visit our website at encova.com.

To the initial medical provider: Section II of this form must be completed by you. The timely provision of information regarding the claimant's condition is vital in deciding eligibility for benefits. Each answer should be as specific as possible. You should immediately send a copy of all records, office notes and test results regarding the claimant's exam to Encova. **Please forward the original completed form to Encova and provide a copy to the claimant.** If you have any questions, contact Encova at 866-452-7425 or visit our website at encova.com.

Special instructions for Section I	
Question 8	This date is defined as either the date you were injured or the date you were last exposed if you are filing an occupational disease claim.
Question 13	Provide your specific job title and describe the duties of the job you are currently working.
Question 15	Please provide as much detail as possible and attach additional pages if space is needed.

Special instructions for Section II	
Question 1, 2	The group and FEIN are required by Encova for billing purposes.
Question 8	Describe in detail what effect, if any, the claimant's previous health may have on this injury.

Please attach additional pages if space is needed and include any appropriate reports.

Return completed form to

Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151

When completing this form, enclose attachments if additional space is needed.

ACCIDENT INVESTIGATION

Every accident should be investigated thoroughly to determine the cause and put preventive measures in place. The investigation should be conducted as soon as possible to get the most accurate information, obtain the facts and prevent recurrence.

STEPS TO FOLLOW

1. ***Receive notification of incident***
2. ***Initiate the investigation***
    a. Secure the scene
    b. Form an investigative team (co-workers, maintenance, engineers, safety, etc.)
    c. Collect the facts
    d. Analyze the facts
3. ***Determine if reporting to authorities such as OSHA, CDC, etc. is required***
4. ***Complete required reports***
    a. Employee Incident Report
    b. Witness statement
    c. Include pictures
    d. Forward report
5. ***Identify***
    a. Root cause(s)
    b. Contributing factor(s)
    c. Corrective action(s)
6. ***Implement corrective action(s)***
    a. Immediate action(s)
    b. Short term
    c. Long term
7. ***Educate employee(s)***

THE QUESTIONS BELOW WILL ASSIST IN DETERMINING THE CAUSATION FACTORS OF THE ACCIDENT AND POSSIBLE CORRECTIVE ACTIONS.

QUESTIONS TO ASK	IF THE CAUSES APPEAR TO BE	
	CONDITIONS	ACTIONS
WHO	was responsible for it? can give me answers? should take corrective action?	is best qualified to do it? can give me answers? can show me what was being done?
WHAT	caused it to exist? caused it to be involved?	was its purpose? other way could it be done? details could be eliminated? instructions were not followed?
WHEN	did it occur? do similar conditions occur?	should it be done?
WHERE	was it? was its source? else does it exist? can I find out?	should it be done? else is it being done?
HOW	should it be corrected? can it be avoided in the future?	is the best way to do it? can it (job or detail) be improved?
WHY	did it exist? had no one noticed and corrected it?	was it being done? was it being done this way? was it (job or detail) necessary?

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