SIMPSON COUNTY BOARD OF EDUCATION

430 South College Street • Telephone (270) 586-8877 • Fax (270) 586-2011
FRANKLIN, KENTUCKY 42134

DR. JAMES FLYNN
SUPERINTENDENT

KEMI - Worker's Compensation

All accidents/injuries must be reported within 24 hours

Employees MUST complete the attached packet when an accident and/or injury occurs during work hours

- Report ALL accidents, even if you do not seek medical attention
- Complete ALL sections of Page 1 marked with an asterisk
  - Please print legibly; you may write on the back of Page 1 if more space is necessary
- Page 2 must be signed & dated where indicated
- Pages 1 & 2 must be turned in to Human Resources
- Page 3 should be given to Adams Medical Clinic in the event medical attention is sought
- Page 4 should be given to the Pharmacy in the event medication is prescribed

PLEASE NOTE: If an injury occurs during normal school/business hours, please visit Adams Medical Clinic for medical attention; if an injury occurs after normal school/business hours, please seek medical attention as you deem appropriate. Human Resources should be notified the morning of the next possible business day. Central Office hours are 7:30 am– 4:00 pm, Monday-Friday.

270-586-8877

SIMPSON COUNTY PROVIDES EQUAL EDUCATIONAL AND EMPLOYMENT OPPORTUNITIES

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

Employer (Name & Address Including Zip)	Carrier/Administration Claim Number	Report Purpose Code
Simpson County Schools BOE 430 South College St. Franklin, KY 42134 Human Resources - Milli McIntosh / Lesley Forshee	Jurisdiction	Jurisdiction Claim Number
	Insured Report Number KY	
	Employer's Location Address (if different)	Location #
SIC Code / Employer FEIN 61-6001281		Phone #

Carrier/Claims Administrator

Kentucky Employers' Mutual Ins. Lexington Financial Center 250 W. Main Street, Suite 900 Lexington, KY 40507 Telephone: (859) 425-7800 Fax: (859) 425-7822	Policy Period 7/1/18 To 6/30/19 Check if Appropriate ☑ Self Insurance	Claims Administrator (Name, Address, Phone No)
Carrier FEIN	Policy/Self-Insured Number 421425	Administrator FEIN
Agent Name & Code Number		

Employee

Name (Last, First, Middle)	Date of Birth	Social Security No.	Date Hired	State of Hire
*	*	*		

Address (include ZIP)	Sex	Marital Status	Occupation/Job Title
*	☐ M – Male ☐ F - Female ☐ U - Unknown	☐ U - Unmarried Single/Divorced ☐ M - Married ☐ S - Separated ☐ K - Unknown	Occupation/Job Title Employment Status
Phone *	# of Dependents		NCCI Class Code

Wage

Rate	Per ☐ Day ☐ Month ☐ Week ☐ Other	**# Days Worked/Week**	Full Pay for Day of Injury? ☐ Yes ☐ No Did Salary Continue? ☐ Yes ☐ No

Occurrence/Treatment

Time Employee Began Work ☐ AM ☐ PM	Date of Injury/Illness	Time of Occurrence ☐ AM ☐ PM	Last Work Date	Date Employer Notified	Date Disability Began
*	*	*			

Contact Name/Phone Number	Type of Injury/Illness	Part of Body Affected
	*	*
Did Injury/Illness exposure occur on employer's premises? ☐ Yes ☐ No	Type of Injury/Illness Code	Part of Body Affected Code

Department or location where accident or illness exposure occurred *	All equipment, materials, or chemicals employee was using when accident or illness exposure occurred *
Specify activity the employee was engaged in when the accident or illness exposure occurred *	Work process the employee was engaged in when accident or illness exposure occurred *
How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill *	Cause of Injury Code

Date Returned to Work	If Fatal, Give Date of Death	Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No Were they Used? ☐ Yes ☐ No

Physician/Health Care Provider (Name & Address)	Hospital (Name & Address)	Initial Treatment
Adams Medical Clinic 119 Memorial Drive Franklin, KY 42134 270-586-9533	The Medical Center at Franklin 1100 Brookhaven Road Franklin, KY 42134	☐ 0 No Medical Treatment ☐ 1 Minor by Employer ☐ 2 Minor Clinic/Hosp ☐ 3 Emergency Care ☐ 4 Hospitalized>24 Hrs ☐ 5 Future Major Medical/ Lost Time Anticipated

Witnesses (Name & Phone #) *

Date Admin/Carrier Notified	Date Prepared	Preparer's Name & Title	Phone Number 270-586-8877

FORM IA-1 **SEE BACK FOR IMPORTANT INFORMATION & SIGNATURE**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. Reprinted with permission of the IAIABC (as modified by and for KEMI).

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Please remember to sign & date the bottom of page 2

EMPLOYER'S INSTRUCTIONS
DO NOT ENTER DATA IN SHADED FIELDS

DATES:
Enter all dates in MM/DD/YY.

SIC CODE:
This is the code that represents the nature of the employer's business that is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

CARRIER:
The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer or the claimant.

CLAIMS ADMINISTRATOR:
Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:
Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:
This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:
Indicate the employee's work status. The valid choices are: Full-Time, Not Employed, Disabled, Unknown, Apprenticeship Part-Time, Seasonal, Part-Time, On Strike, Retired, Apprenticeship Full-Time, Volunteer, and Piece Worker.

DATE DISABILITY BEGAN:
The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwise designated by the statute.

CONTACT NAME/PHONE NUMBER:
Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:
Briefly describe the nature of the injury or illness, (e.g. Lacerations to the forearm).

PART OF BODY AFFECTED:
Indicate the part of body affected by the injury/illness, (e.g. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
(e.g. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210) If the accident or illness exposure did not occur on the employer's premises, enter the address or location. Be specific.

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSRE OCCURRED:
(e.g., Acetylene cutting torch, metal plate)

List all equipment, materials and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
(e.g., Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation of painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (e.g., walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:
(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK: Enter the date following the most recent disability period on which the employee returned to work.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. Reprinted with permission of the IAIABC (as modified by and for KEMI).

Employee Signature: X ______________________________ DATE: ______________

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BHN - KEMI

BLUEGRASS HEALTH NETWORK, INC.

Contact KEMI for pre-certification authorization and hospital admission.

(800) 868-4553

Fax: (859) 425-7822

After Hours: (888) 536-4626

BHN - KEMI

BLUEGRASS HEALTH NETWORK, INC.

Workers' Compensation Managed Care Organization for Kentucky Employers' Mutual Insurance

Health Care Providers:
Send bills and medical information to:
KEMI: Attn. Claims
250 West Main Street, Suite 900
Lexington, KY 40507

This is not a guarantee of eligibility for Workers' Compensation Benefits.

tmesys®

First Fill
Temporary Pharmacy Card

Making it easy to get your workers' compensation prescriptions filled.

Just follow these easy steps...

Employer:

Immediately upon receiving notice of injury, fill in the information below and give it to your employee.

Injured Employee:

1. If you need a prescription filled for a work-related injury or illness, go to a Tmesys network pharmacy.
2. Give this page to the pharmacist.
3. The pharmacist will fill your prescription at no cost.

tmesys®
Prescription Card

KEMI

CARRIER / TPA: KEMI
EMPLOYER:
INJURED WORKER NAME:
SOCIAL SECURITY NUMBER:
DATE OF INJURY:

Notice to Cardholder: This card should be presented to your pharmacy to receive medication for your work-related injury. It is only valid within 30 days of your date of injury. For information regarding the program or to find nearby pharmacies call **866.599.5426.**

Attention Pharmacists: Call **800.964.2531** to establish First Fill benefit eligibility and obtain the ID# for online adjudication of approved benefits for the injured worker.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy
Help Desk 800.964.2531

	NDC		Envoy
RxBin	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #

(To create a card for your wallet, cut along outer line and fold in half.)

Pharmacist:

1. Call the Tmesys Pharmacy Help Desk at **800.964.2531.**
2. Provide the information listed above.
3. The Help Desk will provide an ID number for adjudication.

Finding a Network Pharmacy

Use one of these easy methods to find a network pharmacy:

- Visit your local **Walgreens** or **Rite Aid** Pharmacy
- Call us: **866.599.5426**
- Use our pharmacy locator online: **www.pmsionline.com/pharmacy-center**.

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