RISK ADMINISTRATION SERVICES, INC.

EMPLOYEE INJURY REPORT

Claim No.:

INJURED WORKER INFORMATION

Last Name:	First Name:	MI:	Date of Birth:	SSN:

Address:	City:	State:	Zip:

Marital Status: ☐ Married ☐ Unmarried	Gender: ☐ Male ☐ Female	Dependents:	Phone:	Email:

EMPLOYMENT INFORMATION

Employer:	Employer Address:	Yrs employed:

At the time of injury were you employed anywhere else? (**If yes please fill out the following**):

Employer Name: Address: Duties:

Name and address of your former employers:	Have you ever filed a Workers' Compensation claim? ☐ Yes ☐ No When: Employer:

INJURY INFORMATION

Date of Injury:	Time of Injury: ☐ AM ☐ PM	Date you reported injury:	Name/title of person you reported to:

Describe how and what happened to cause this injury:	Where were you when injury occurred?

Name all injuries from this accident:

Have you ever suffered any injuries either work or non-work related before? ☐ Yes ☐ No (**If yes please explain):**

Are you working? ☐ Yes ☐ No	Did you miss work? ☐ Yes ☐ No	Were you paid for any part of time lost? ☐ Yes ☐ No	Date(s) of lost time:

Witnesses:	**TRUCKING ONLY:** Where did your Employer administer your Qualification Tests? **City/State**

Was your injury the result of someone else's negligence? ☐ Yes ☐ No **(If yes, please fill out the following):**

Name:_____ Address:_____ Phone: _____

Insurance Co.:_____ Policy or Claim No.: _____

TREATMENT INFORMATION

Date of first medical treatment:	Are you still under a Dr's care? ☐ Yes ☐ No	Date of most recent treatment?	Are you covered by your spouse's ☐ Yes ☐ No health insurance?

Name and Addresses of all doctors and hospitals treating you:

Have you had previous problems or treatments to this body area(s) ☐ Yes ☐ No **(If yes, please describe and include dates experienced):**	Please list name/address of Group Health Ins:

Employee Signature:	**Date:**

OFFICES IN SOUTH DAKOTA AND MINNESOTA
Mailing Address: PO Box 89310, Sioux Falls, SD 57109-9310
Phone. 800.732.1486 | **Fax.** 877.884.6573| **Email:** www.RASCompanies.com

RISK ADMINISTRATION SERVICES, INC.

Injured Worker:

Claim No.:

Date of Birth:

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my medical information (also known as protected health information) as described below.

Facility Name: _____

Enter the name of doctor's office, hospital, or other healthcare facility you are authorizing to send us your medical information.
Use separate form for each if more than one.

I, _____, authorize all persons or entities that provided medical treatment to me to disclose the following medical information in your possession to RAS, its employees, agents, subcontractors and authorized representatives.

Please provide RAS with any and all information in your possession concerning my physical condition, past, present and future, including but not limited to, healthcare history, diagnosis, condition, treatment or evaluation and other medical information so that they may use it or disclose it to evaluate, administer and resolve my claim related to injuries I received on _____. I understand that the medical information that is disclosed may include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. *

I, _____, authorize the State to release to Insurer/RAS and/or its representatives a complete copy of all records pertaining to past or present Workers' Compensation claims.

I hereby authorize Insurer/RAS to reproduce, distribute or use any or all protected health information from any past or present Workers' Compensation claims that I may have had with Insurer/RAS. I further authorize Insurer/RAS to retain any or all protected health information it may receive related to the injury I received on _____.

This authorization shall be in force and effective until my claim related to the injury, I received on _____ is resolved, at which time this authorization to use or disclose this protected health information expires. I understand that I may revoke this authorization by notifying [**RAS Inc, PO Box 89310, Sioux Falls, SD 57109**] in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by RAS or the Releasing Party in Reliance on it before I revoked it.

As the person signing this Authorization for Release of Protected Health Information, I understand that I am giving permission to RAS to obtain and use protected health information. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

A copy of this authorization may be accepted with the same authority as the original.

I understand this authorization is voluntary. As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the **health care entity** may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. While I do not need to sign this authorization to ensure **healthcare treatment**, I understand that failure to do so may have impact on my entitlement to payment of Workers' Compensation benefits.

Print Name of Patient or Personal Representative	Description of Personal Representative's Authority
X **Signature of Patient or Personal Representative**	Date

*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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RISK ADMINISTRATION SERVICES, INC.

RETURN TO WORK REPORT

TO BE COMPLETED BY **ATTENDING PHYSICIAN** AND RETURNED TO EMPLOYER IMMEDIATELY FOLLOWING EACH APPOINTMENT.

Patient Information:

Last Name:	**First Name:**	**MI:**

Date of Injury:	**Date of Treatment:**	**Brief Explanation of Diagnosis/Condition:**

Limitations:

Based on the above description of the patient's current medical problem, I am recommending the following:

☐ Patient may return to work with no limitations on: _____

☐ Patient may not return to work with limitations listed below.

☐	**SEDENTARY WORK** Lifting up to 10 pounds occasionally and frequently lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties.	In an ____ hour work day, patient may: **Stand:** ☐ None ☐ 1-4 Hours ☐ 4-6 hours ☐ 6-8 hours
☐	**LIGHT WORK** Lifting up to **20 lbs** occasionally with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pull of arm and/or leg controls.	**Sit:** ☐ 1-3 hours ☐ 3-5 hours ☐ 5-8 hours **Drive:** ☐ 1-3 hours ☐ 3-5 hours ☐ 5-8 hours ☐ 8+ hours
☐	**MEDIUM WORK** Lifting **50 lbs** maximum and frequent lifting or carrying of objects weighing up to 25 lbs.	**Patient may use hand(s) for repetitive:** ☐ Single Grasping ☐ Fine Manipulation ☐ Pushing/Pulling ☐ Firm Grasping ☐ Patient is not to use injured hand
☐	**LIGHT-HEAVY WORK** Lifting **75 lbs** maximum and frequent lifting or carrying of objects weighting up to 40 lbs.	**Patient is able to:** ☐ Bend ☐ Squat ☐ Kneel ☐ Climb stairs ☐ Reach above shoulders
☐	**HEAVY WORK** Lifting **100 lbs** maximum and frequent lifting or carrying of objects weighing up to 50 lbs.	**Patient may use foot/feet for repetitive movement as in operating foot controls.** ☐ Yes ☐ No
Condition: ☐ Worse ☐ Discharged ☐ Improved ☐ Resolved ☐ Reach above shoulders		**No Change in:** ☐ Diagnosis ☐ Treatment ☐ Work Restriction

Other instructions and/or limitations, including prescribed medications:

☐ **These restrictions are in effect until:**	☐ **Or until patient is re-evaluated on:**

☐ **Patient is totally incapacitated at this time and a re-evaluation is scheduled on:**

Physician's Signature:	**Date:**

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INFORMATION FOR INJURED EMPLOYEES

K-WC 27-A (Rev. 2-14)

* THIS NOTICE APPLIES TO ACCIDENTS ON OR AFTER APRIL 25, 2013 *

Employers are required to provide this information to each injured worker

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

If you have any questions about workers compensation benefits, contact the Division of Workers Compensation at the phone number at the bottom of the page. **Assistance in Spanish is available.**

(1) NOTIFY YOUR EMPLOYER IMMEDIATELY: Per K.S.A. 44-520, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates: (A) 20 calendar days from the date of accident or the date of injury by repetitive trauma; (B) if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma, 20 calendar days from the date such medical treatment is sought; or (C) if the employee no longer works for the employer against whom benefits are being sought, 10 calendar days after the employee's last day of actual work for the employer.

Notice may be given orally or in writing. Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manager.

Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.

The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the workers compensation act or has suffered a work-related injury.

(2) FOLLOW YOUR EMPLOYER'S INSTRUCTIONS for getting medical aid and follow the doctor's instructions.

(3) MEDICAL BENEFITS: An injured worker is entitled to all medical services reasonably necessary to cure and relieve the worker from the effects of the injury. The employer has the right to select the doctor who will treat the injury. A worker may seek the services of an unauthorized doctor up to a limit of $500.00. A worker may apply to the Workers Compensation Director to change the authorized treating doctor. Reimbursement for travel to obtain medical treatment is payable at a rate set by law for trips that are five miles or more (round trip).

(4) WEEKLY BENEFITS: Benefits are paid by the employer's insurance carrier or self insurance program. Injured workers are not entitled to compensation for the first week they are off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 ⅔ percent of his/her average weekly wage up to a maximum of 75 percent of the state's average weekly wage. These benefits are subject to legislative changes. If the injury results in permanent disability, the Kansas Workers Compensation law provides for additional benefits.

This notice must be posted and maintained by the employer in one or more conspicuous places.

Workers Compensation Rights and Responsibilities

Your employer is subject to the Kansas Workers Compensation Law which provides compensation for job-related injuries.

This notice applies to dates of accidents on or after April 25, 2013.
Este aviso aplica a las fechas de los accidentes a partir de Abril 25, 2013.

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Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.

The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the workers compensation act or has suffered a work-related injury.

BENEFITS. Benefits are paid by the employer's insurance carrier or self insurance program. Benefits include medical treatment, partial wage replacement for lost time and additional benefits if the injury results in permanent disability. An employer is required to furnish all necessary medical treatment and has the right to designate the treating physician. If the employee seeks treatment from a doctor not authorized by the employer, the employer or its insurance carrier is only liable up to $500.00 dollars for the unauthorized medical treatment.

QUE HACER SI UNA LESIÓN OCURRE EN EL TRABAJO

NOTIFIQUE A SU EMPLEADOR INMEDIATAMENTE. De acuerdo con el artículo de ley K.S.A. 44-520, un reclamo puede ser negado si el empleado no notifica a su empleador dentro de antes de las siguientes fechas: (A) **20 días** a partir de la fecha del accidente o la fecha de la lesión debido a trauma por movimientos repetitivos; (B) si el empleado está trabajando con el empleador en contra del cual se están buscando beneficios y dicho empleado busca tratamiento médico por cualquier lesión por accidente o trauma repetitiva, **20 días** a partir de la fecha que dicho tratamiento médico ha sido obtenido; o (C) si el empleado ya no trabaja para el empleador en contra del cual se están buscando beneficios, **10 días** después del último día de trabajo para dicho empleador.

El aviso puede darse oralmente o por escrito. Donde el aviso se da oralmente, si el empleador ha designado un individuo o departamento a quien el aviso se debe dar y tal designación ha sido comunicada por escrito al empleado, aviso a cualquier otro individuo o departamento deberá ser insuficiente bajo esta sección. Si el empleador no ha designado a un individuo o departamento a quien se debe dar el aviso, el aviso puede darse a un supervisor o gerente.

Donde el aviso se hace por escrito, el aviso debe ser enviado a un supervisor o gerente de la oficina principal de empleo del trabajador.

El aviso, sea que se haga oralmente o por escrito, debe incluir la hora, fecha, lugar, persona lesionada y detalles de tal lesión. Debe ser visible a partir del contenido del aviso, que el empleado está reclamando beneficios bajo la ley de compensación del trabajador o que ha sufrido una lesión relacionada con el trabajo.

BENEFICIOS. Los beneficios son pagados por la compañía aseguradora del empleador o programa de seguro propio. Los beneficios incluyen tratamiento médico, reemplazo de sueldo parcial por tiempo perdido y beneficios adicionales si la lesión resulta en incapacidad permanente. El empleador debe proporcionar todo el tratamiento médico necesario y tiene el derecho de designar el doctor para dicho tratamiento. Si el empleado busca tratamiento con un doctor que no ha sido autorizado por el empleador, el empleador o su compañía aseguradora serán responsables de pagar solamente los primeros $500.00 dólares para tratamiento médico no autorizado.

WHERE TO GET HELP WITH YOUR CLAIM (DÓNDE CONSEGUIR AYUDA CON SU RECLAMO):

_____ (_____) _____

Employer's Insurance Carrier (Compañía Aseguradora del Empleador) — Telephone (Teléfono de la Aseguradora)

_____

Address (Dirección de la Aseguradora)

For questions about Workers Compensation Law, contact (Para preguntas acerca de la Ley de Compensación del Trabajador):

KANSAS DEPARTMENT OF LABOR
Division of Workers Compensation/Ombudsman
401 SW Topeka Blvd., Suite 2, Topeka, KS 66603-3105

Website: www.dol.ks.gov/workcomp/default.aspx
Email: wc@dol.ks.gov
Phone: (800) 332-0353 or (785) 296-4000

Persons with impaired hearing or speech utilizing a telecommunications device may access the above number(s) by using the Kansas Relay Center at (800) 766-3777.

First Fill Instructions for RAS

Dear Injured Claimant,

Alius Health is a business partner of RAS and has been selected to administer your injury prescription drug plan. Attached is your temporary prescription card allowing up to a 10-day supply of medication. Once your claim has been accepted by RAS, a replacement prescription card will be sent to you if you require ongoing treatment. The new card will allow monthly medications related to your injury.

Our extensive pharmacy network includes those below. Simply present this letter along with your prescription(s) to a participating pharmacy. To verify if your preferred pharmacy is in the network, you can use our pharmacy locator on www.Aliushealth.com or call 740-661-4463. Our office hours are Monday through Friday 9am – 7pm Eastern Standard Time.

Name:

Member ID: ALIUS

Member ID *is DOB (YYYYMMDD) and last 4 digits of SSN*
Example: **ALIUS194401011234**

Person Code: 01
RxGroup #: ALHFF1320216999
RxBIN/IIN: 610729
RxPCN: ALIUS

ATTENTION PHARMACISTS: Please process prescriptions through **Script Care**. For questions, please call Alius Health 740-661-4463

ATTENTION INJURED CLAIMANT: The use of this prescription card is restricted to your allowed injury' condition only. Possession of this card does not guarantee benefits.

Albertsons	Discount Drug Mart	Good Neighbor Pharmacy	Long's Drug	Sam's Club
BI-LO	Drug Emporium	H E B Drug stores	Medicine Shoppe	Shopko
Bartell Drugs	Family Pharmacy	Health mart	Meijer	Shoprite
Brooks Pharmacy	Fred's	Hy-Vee	Publix	Supervalu
Costco	Fruth Pharmacy	Kroger	Rite Aid	Walgreens
CVS	Giant Eagle Pharmacy	Lewis Drug	Safeway	Walmart

Estimado Trabajador,

Alius Health es socio de RAS ya ha sido seleccionado para administrar su plan de medicamentos recetados para su lesiones. Aquí esta su tarjeta de prescripción temporal que permite hasta 10 días de medicamento. Una vez que su reclamación ha sido aceptada por RAS, se le enviara una tarjeta de reemplazo para requerir tratamiento continuo. La tarjeta nueva le va a permitir medicamentos mensualmente relacionados a su lesion.

Nuestra extensa red de farmacias include las siguientes. Simplemente present esta carta junto con su recetas a una farmacia participantes. Para verificar si su farmacia preferida esta en nuestra red de farmacias puede utilizar nuestro localizador de farmacia en www.Aliushealth.com o llamar 740-661-4463. Nuestra horas de operación son de Lunes a Viernes de 9:00am-7:00pm tiempo de oeste.