DWC FORM-001
(Employer's First Report of Injury or Illness)

The **employer** is required to file an **Employer's First Report of Injury or Illness** [DWC FORM-001 Rev. 10/05] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

The **Employer's First Report of Injury or Illness** provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. Details of the claimant's employment and circumstances surrounding the injury or illness are also requested.

Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

[Workers' Compensation Rule 120.2]

FISD Workers Compensation Specialists

Email or Fax to: **Dafne Rodriguez / Lorie Turner**
Email address: **workerscomp@friscoisd.org**
Phone: 469-633-6346 / 469-633-6341
Fax: 469-633-6325

FISD WC Administrator
Janet Leonardo
Email: **leonardoj@friscoisd.org**

INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-001)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Section 409.005, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM-001 Rev. 10/05 to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Section 409.006. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.** The Division's Health and Safety will use data from this report for the Job Safety Information System established in Section 411.032 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2,7,8:	Section 402.082, Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
Item 4:	If no home phone, please provide a phone number where the employee can be reached.
Items 5,15,17, 26,29,30:	Enter data in month, day, year format. Example: 08-13-54.
Item 18:	List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.
Item 19:	List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
Item 20:	Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
Item 22:	State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.
Item 24:	List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.
Items 32,33:	Enter date in month-year format. Example: 02-56.
Item 37:	Enter the number of days or hours that make up a full work week for your employees.
Item 45:	Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.
Item 46:	For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

Email or Fax to: Dafne Rodriguez or Lorie Turner
Email: workerscomp@friscoisd.org
Phone: Dafne 469-633-6346 / Lorie 469-633-6341
Fax: 469-633-6325

CLAIM # _____

Employee ID #

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F☐ M☐

3. Social Security Number - -

4. Home Phone ( )

5. Date of Birth (m-d-y) - -

6. Does the Employee Speak English? YES☐ NO☐ If No, Specify Language

7. Race White☐ Black☐ Asian☐

8. Ethnicity Hispanic☐ Native American☐ Other☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status Married☐ Widowed☐ Separated☐ Single☐ Divorced☐

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name

14. Doctor's Mailing Address (Street or P.O.Box)

City State Zip Code

15. Date of Injury (m-d-y) - -

16. Time of Injury : am☐ pm☐

17. Date Lost Time Began (m-d-y) - -

18. Nature of Injury*

19. Part of Body Injured or Exposed* *Right, Left, Both sides?*

20. How and Why Injury/Illness Occurred*

21. Was employee doing his regular job? YES☐ NO☐

22. Worksite Location of Injury (stairs, dock, etc.)* By classroom #

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site

Choose Location

City State Texas Zip Code

24. Cause of Injury(fall, tool, machine, etc.)*

25. List Witnesses

26. Return to work date/or expected (m-d-y) - -

27. Did employee die? YES☐ NO☐

28. Supervisor's Name

29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y) - -

31. Was employee hired or recruited in Texas? YES☐ NO☐

32. Length of Service in Current Position Months _____ Years _____

33. Length of Service in Occupation Months _____ Years _____

34. Employee Payroll Classification Code

35. Occupation of Injured Worker

36. Rate of Pay at this Job $_____Hourly $___Weekly

37. Full Work Week is: Hours Days

38. Last Paycheck was:

39. Is employee an Owner, Partner, or Corporate Officer? YES☐ NO☐

40. Name and Title of Person Completing Form
Janet Leonardo - FISD Risk Management/Workers Compensation

41. Name of Business
Frisco ISD

42. Business Mailing Address and Telephone Number
Street or P.O. Box
5515 Ohio Drive
Telephone
(469) 633-6345

City State Zip Code
Frisco TX 75035

43. Business Location (If different from mailing address)
Number and Street
5515 Ohio Drive

City State Zip Code
Frisco TX 75035

44. Federal Tax Identification Number
75-6001636

45. Primary North American Industry Classification System
Code:(6 digit) **611110**

46. Specific NAICS Code (6 digit)
611110

47. Texas Comptroller Taxpayer No.
75-6001636

48. Workers' Compensation Insurance Company
Claims Administrative Services

49. Policy Number
Self-Insured

50. Did you request accident prevention services in past 12 months?
YES☐ NO☐ If yes, did you receive them? YES☐ NO☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____

Employee Injury Report

This form must be completed in detail and signed by the injured employee.

Employee Information

Your Full Name		
Employer Frisco Independent School District		Location of Accident
Social Security Number (Last 4 Digits) XXXX-XX-	Date of Birth	Department You Work For
Your Address (Street, City, State, County, Zip)		Supervisor's Name
Phone Number Where You Can Be Reached		Job Title at Time of Injury
Date of Hire		How Long in Current Position? _____Yrs. _____ Months

Details of the Injury

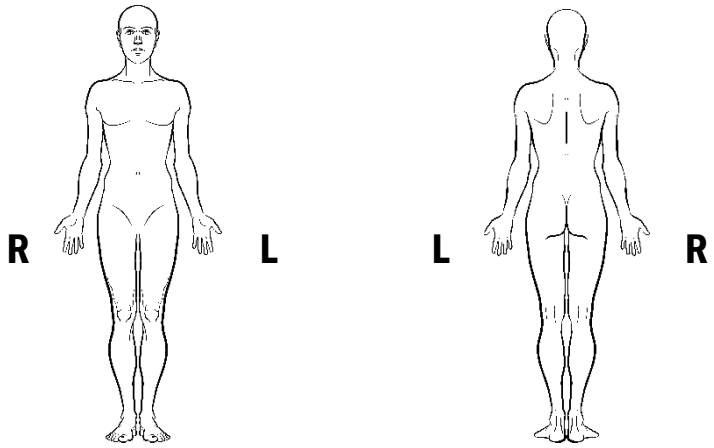
Date of Injury	Time of Injury AM / PM ☐ ☐	Date You First Lost Time
Where in the workplace did your injury occur?		
Describe in detail how your injury occurred.		
What safety equipment were you using at the time of the accident?		
What can be done to prevent this type of injury in the future?		
When were you first aware of this injury?		
When did you first notify your supervisor of your injury?		

Employee Injury Report

What part of your body is injured?	Describe the injury.

On the diagram below, please circle the part(s) of your body where you are experiencing pain due to this injury.

*Click on the icon on the upper right side of the tool bar above.
*With the circle visible, PRESS & HOLD the mouse over the injured area to create the highlight.
* ***If the icon is hidden***, press F8 to reveal the toolbar.



Did anyone witness your accident? List the names of any witnesses.

Was anyone else injured in this accident? List the names of any other injured people.

In the incident that caused your injury, was there damage to any property or equipment? Describe any damage.

- ✓ **I certify that the information contained in this report is true and correct.**
- ✓ **I understand that any falsification of information regarding an on-the-job injury may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes.**
- ✓ **I hereby authorize the release of all medical records relating to the above-noted incident to my employer, their agent, or insurance company.**

Employee's Printed Name	**Employee's Signature**	**Date**

- ✓ **I certify that the above employee has acknowledged to me that he/she understood all questions and signed and dated this form in my presence on this date.**

Witness Printed Name	**Witness Signature**	**Date**

Supervisor's Printed Name	**Supervisor's Signature**	**Date**

HIPPA Authorization Form

Disclosure of Protected Health Information

I, *(Name)* _____, *(Date of Birth)* _____, *(SSN)* _____, authorize the disclosure of my protected health information* as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws**, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below):
   + **All healthcare providers who have provided healthcare to me.**
2. I authorize the following person(s) and/or organizations to receive my protected health information as disclosed by the person(s) and/or organization(s) above.
   + **Claims Administrative Services, Inc.**
     P.O. Box 7500, Tyler, Texas 75711
   + **Texas Department of Insurance – Division of Workers' Compensation**
     7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1609
   + **Others: _____**
3. Specific description of the protected health information that I authorize for disclosure:
   + **Any and all records regarding my health, including medical histories, consultations, examinations, prescriptions, diagnoses, tests, reports, or treatments.**
   + **I further specifically authorize the disclosure of psychotherapy notes, if any.**
4. The purpose of requesting this information is for use by the carrier to evaluate, adjust, describe, or report matters about my health to persons entitled to receive this information.
5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.
6. I understand that treatment and payment for my treatment are not conditioned on my agreement to this authorization.
7. I understand that the release of protected health information to a non-covered entity may invalidate its protection.
8. I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all healthcare information related to such diagnosis, testing, or treatment.
9. This authorization expires one year from the date of authorization or the date that my workers' compensation claim is finally closed, whichever occurs first.

I have had the opportunity to read and consider the contents of this authorization. I confirm that this authorization is a true and correct statement of my intention to permit the disclosure of my PHI as described in this authorization.

Signature	**Date**

Name		
Address		
Phone Number	**SSN (Last 4 Digits Only)** **XXX-XX-**	**Date of Birth**

*Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse that relates to 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508 **These laws apply to health plans, health care providers, and health care clearinghouses.

FRISCO ISD WORKERS' COMPENSATION PROGRAM EMPLOYEE INFORMATION SHEET

GENERAL INFORMATION

The Frisco Independent School District (Frisco ISD) provides workers' compensation benefits to employees who are injured at work. This benefit will cover only a work-related injury or illness, not other medical problems. Once a claim is reported and accepted by the Frisco ISD workers' compensation program as compensable (eligible), your workers' compensation benefits begin. This is the only medical benefit you may use for treatment of your specific claim/injury, including medical examinations and medications.

The Frisco ISD workers' compensation program pays for healthcare reasonably required using evidence-based medicine in accordance with the Official Disability Guidelines (ODG) to treat a compensable injury. **Workers' compensation claims should not be processed via personal health insurance.**

The Frisco ISD Employee Health Benefit Plan will not cover any expenses for which you should be receiving workers' compensation benefits, and you cannot use your prescription card for medications related to your injury. Workers' compensation benefits apply only if the claim is found to be compensable. A claim that is reported more than 30 days after it occurs will be denied or disputed.

WORKERS' COMPENSATION CLAIMS PROCESS:

INITIAL REPORTING AND DOCUMENTATION

If you are injured at work, think the injury was caused by work, or a doctor tells you the injury/illness is work related, the following steps must be taken:

1) **You must immediately report the incident to your school nurse, your supervisor, or to Workers' Compensation.**
    a. The campus nurse or supervisor must fill out the form DWC-1.
    b. Employees fill out the Claims Administrative Services (CAS) Workers' Compensation Supplemental Injury Report.
    c. You may be asked questions to enable the Nursing, Management, or Risk Management staff to complete the state required Employer's First Report of Injury Form.
    d. We will need to know what, when, and where the injury occurred, who was involved, what part of your body was injured, what caused the accident, and who saw it happen.
2) **Healthcare**
    a. An injured employee must establish care with a treating provider that accepts workers' compensation.
    b. As a courtesy, a list of providers who accept workers' compensation insurance is within this packet.
    c. The treating provider is responsible for managing care and specialist referrals.

d. Email workers' compensation bills to workerscomp@friscoisd.org for review and processing.

3) If you have any questions or need information relating to your claim contact:

Janet Leonardo
leonardoj@friscoisd.org
FISD Workers' Compensation Administrator
Central Administration
Direct Line: 469-633-6345

Dafne / Lorie
workerscomp@friscoisd.org
FISD Workers' Compensation Specialist
Central Administration
Direct Line:
Dafne R.: 469-633-6346
Lorie T.: 469-633-6341
Fax Number: 469-633-6325

4) An Election of Benefits letter will be emailed to you if you are losing time.

As outlined by the Texas Department of Insurance, workers' compensation income benefits begin on the eighth day of disability. Income benefits are not payable for the first seven days unless the disability extends beyond 14 days. During this waiting period, employees may choose to apply their accrued leave time to maintain income.

a. The letter is to confirm that you have elected to voluntarily use your available accrued leave to cover the initial seven (7) calendar day waiting period required under the Texas Workers' Compensation Act.

b. If you do not lose more than (7) days and do not have any accrued time available, your payroll may be docked.

c. There are (3) options to choose from. Details within the letter will be emailed.

d. After the seventh day of absence with no election of benefits letter on file, the district workers' compensation program will issue Temporary Income Benefits (TIBS). TCP/WillSub+ will be coded Dock-Workers Comp.

5) Temporary Income Benefits

You may qualify for TIBS if your work-related injury or illness causes you to lose all or part of your income for more than seven (7) calendar days.

a. TIBS are calculated as 70% of the difference between your average weekly wage before the injury and what you're able to earn after the injury.

b. TIBS are subject to maximum ($1,219) and minimum ($183) benefit amounts set by the Texas Department of Insurance.

c. You must notify the Workers' Compensation Department immediately if you pay child support.

d. It is the responsibility of the employee to keep track of the days or times used to treat the compensable injury and communicate that information promptly to workerscomp@friscoisd.org.

6) Mailed documents

a. Be sure to monitor any mail sent to your home. Some documents may require a response or action within a specific timeframe.

7) Follow-up care (i.e., physical therapy, doctor re-checks, etc.)

Workers' Compensation does not cover paid time off for follow-up medical care.

a. Most workers' compensation medical providers have hours to accommodate an after-work appointment.
b. You should report to your supervisor each time you go to the doctor.
c. The doctor should give you a work status report DWC-73 form after the appointment. Please forward your work status note to workerscomp@friscoisd.org for timely processing.
d. If your treating doctor releases you to return to work with modified physical restrictions, contact the Workers' Compensation Department to determine if FISD will be able to accommodate your restrictions.
e. You must have a return-to-work release form (DWC-73) from your treating physician to return to your full regular duties.

The FISD Workers Compensation program is administered by:

Claims Administrative Services
Phone: 1-800-765-2412
Email: claimsmail@cas-services.com
Fax: 1-903-509-1888

501 Shelley Drive
Tyler, Texas 75701

Additional information may be obtained from:
https://www.tdi.texas.gov/wc/employee/index.html

Prescription Card Information

If prescriptions are issued during the course of treatment for your work-related injury, the following information will help guide you through the process of accessing necessary medications. Your prescription program is processed by MyMatrixx and this packet contains your "Temporary Prescription Card" as well as a list of "Participating Pharmacies." Below are some common questions about how the card works, its benefits, and how to use it effectively.

What is this card?

This card is for your workers' compensation prescription needs. Please take this card to the pharmacy when you are filling prescriptions for your work-related injury.

Why did I receive this card?

You received this card due to an injury that occurred on the job.

What if I am not currently taking any medications due to the injury?

Please keep the card in a safe place in case you start taking medications for your current injury.

When should I use this card?

Any time you need to fill a prescription for your work-related injury.

Are all medications pre-approved?

Your insurance company may have pre-selected medications that will go through without authorization. If you drop off a prescription at the pharmacy and it is rejected for any reason, the pharmacy should call us and we will call your insurance company for approval. If you would like to know the types of medications that are pre-approved before going to the pharmacy, please call 877-804-4900, and a customer service representative will be happy to assist you.

Can my family members use this card?

No, this is only for your work-related injury.

What should I do if there is a problem with the card when I take it to the pharmacy?

Your pharmacy should call us with any problems they are having with the card. If for ANY reason they do not call us, or if you have any questions regarding your work-related medications, please call our customer service team at 877-804-4900.

Are you my workers' compensation insurance company?

No, we are contracted by your workers' compensation insurance company to handle all of your work-related prescription needs.

What happens if my medication doesn't provide relief from my symptoms or pain?

You should contact your doctor or pharmacist to verify that the medication prescribed for your pain is the most appropriate for your condition.

Should I tell my doctor about other medications I am taking not related to my work injury?

Yes. It is very important that your physician and pharmacist know ALL the medications you are currently taking. Some medications may counter the effect of other medications you are taking and some may even be harmful or life-threatening when taken together.

Can I talk to one of your pharmacists if I have a question?

Yes, our pharmacists are available to answer all of your medication-related questions.

MyMatrixx

By EVERNORTH

To the Injured Worker:

On your first visit, please give this form to any pharmacy listed on the back side to speed processing of your approved work-related injury prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the MyMatrixx Patient Care Contact Center at 800.945.5951.

Atencion Trabajador Lesionado:

En su primera visita, entregue este formulario a cualquier farmacia que se encuentre en el reverso del boleto para acelerar el procesamiento de sus recetas aprobadas para lesiones relacionadas con el trabajo (según las reglas establecidas por su empleador).

¿Tiene preguntas o necesita ayuda para localizar una farmacia participante? Llame al centro de contacto para pacientes de MyMatrixx al 800.945.5951.

Temporary Prescription Card

ID#: _____
Your SSN is your temporary ID.

RxBIN#: 003858

PCN: WC

RxGroup #: PAWA

Date of Injury: _____
MM/DD/YYYY

For Workers' Compensation Only

Employee Information

_____
Full Name

_____
Street Address or PO Box

_____
City State ZIP

_____
Date of Birth

Frisco Independent School District
Employer Name

To the Pharmacist:

MyMatrixx administers this Workers' Compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 30-day supply or a cost of $500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary.

For assistance, please call MyMatrixx at 888.786.9640.

Processing Steps:

1. Enter RxBin 003858
2. Enter PCN WC
3. Enter Rx Group Number PAWA
4. Enter 9-digit member ID (Patient SSN)
5. Enter Date of Injury

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

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MyMatrixx
By EVERNORTH

Participating Pharmacy List

AHF PHARMACY
AHOLD CORPORATION
ALBERTSONS
ALIGNRX LLC
AMERITA INC
AURORA PHARMACY INC
BIG Y FOODS INC
BI-LO HOLDINGS LLC
BROOKS/MAXI DRUG
BROOKSHIRE BROTHERS LTD
CARDINAL HEALTH
CHEN NEIGHBORHOOD MEDICAL CENT
COBORN'S INC.
COSTCO WHOLESALE, INC
CVS CORP
DEDICATED US HOLDINGS LLC
DISCOUNT DRUG MART
ECKERD
EPIC PHARMACY NETWORK
ESSENTIA HEALTH
EXPRESS RX
FAIRVIEW PHARMACY SVCS
FAMILY FARE, LLC
FOOD LION PHARMACY
FRUTH PHARMACY
GENOA HEALTHCARE LLC
GIANT EAGLE PHARMACY
GUARDIAN PHARMACY LLC
HAC INC
HANNAFORD BROS. CO.
HARPS FOOD STORES INC
HARTIG DRUG
HEALTH MART ATLAS LLC
H-E-B LP
HENRY FORD HEALTH SYSTEM
HOMETOWN PHARMCY INC
HY-VEE FOOD STORES INC
INGLES MARKETS
INSTYMEDS CORP
KPH HEALTHCARE SERVICES
KS PHARM LLC
K-VA-T FOOD STORES INC
LEWIS DRUGS INC
LONGS DRUG STORE
MARC GLASSMAN INC
MEDICAP PHARMACY, INC.
MEDICINE SHOPPE
MEIJER PHARMACY
MERCY PHARMACY SERVICES
NCS HEALTHCARE
NEIGHBORCARE PHARMACY
OSBORN DRUGS INC
PATIENT FIRST
PHARMEDQUEST PHARMACY
PHARMERICA, INC
PMR US HOLDINGS
PRESBYTERIAN MEDICAL
PRESCRIBEIT RX
PRICE CHOPPER PHARMACY
PUBLIX SUPER MARKETS, INC
RALEY'S
RECEPT PHARMACY LP
RITE AID CORPORATION
SAFEWAY, INC.
SAM'S CLUB
SUPERVALU PHARMACIES, INC.
TARGET
THRIFTY WHITE STORES
TOPS MARKETS LLC
UNITED SUPERMARKETS INC
WALGREENS
WAL-MART
WEGMANS FOOD MARKETS,
WEIS MARKETS INC

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

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Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System

As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). This assistance is offered at local offices across the State. These local offices also provide other workers' compensation system services from the Texas Department of Insurance (TDI). TDI is the State agency that administers and regulates the workers' compensation system through the Division of Workers' Compensation (DWC).

Many services provided by OIEC and DWC can be completed over the telephone. You can contact OIEC by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). Additional information, including office locations, is available on the Internet at: www.oiec.texas.gov. You can contact DWC by calling the toll-free telephone number 1-800-252-7031. Information about DWC is available on the Internet at: www.tdi.texas.gov.

Your Rights in the Texas Workers' Compensation System:

1. **You have the right to hire an attorney to help you with your workers' compensation claim.**
   For assistance locating an attorney, contact the State Bar of Texas' lawyer referral service at 1-877-983-9227 or http://www.texasbar.com/. Attorney referral information can also be found on OIEC's website at www.oiec.texas.gov.

2. **You have the right to receive assistance from OIEC if you do not have an attorney.**
   OIEC Customer Service Representatives and Ombudsmen are available to answer your questions and provide assistance with your workers' compensation claim by calling OIEC or visiting an OIEC office. **You must sign a written authorization before an OIEC employee can access information on your claim.** Call or visit an OIEC office to fill out the written authorization. Customer Service Representatives and Ombudsmen are trained in the field of workers' compensation and can help you with scheduling a dispute resolution proceeding about your workers' compensation claim. An Ombudsman can also assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot make decisions for you or give legal advice.

3. **You may have the right to receive medical and income benefits regardless of who was at fault for your injury, with certain exceptions. Your beneficiaries may be entitled to death and burial benefits.**
   Information about the exceptions can be found at www.tdi.texas.gov or by visiting with OIEC staff.

4. **You may have the right to receive medical care to treat your workplace injury or illness for as long as it is medically necessary and related to the workplace injury.**
   You may have the right to reimbursement of your incurred expenses after traveling to attend a medical appointment or required medical examination if the trip meets qualifying conditions.

5. **You may have the right to receive income benefits for your work-related injury.**
   There are several types of income benefits and eligibility requirements. Information on the types of income benefits that may be available and the eligibility requirements can be found at www.tdi.texas.gov or by visiting with OIEC staff.

6. **You may have the right to dispute resolution regarding income and medical benefits.**
   You may request Medical Dispute Resolution if you disagree with the insurance carrier regarding medical benefits. You may request Indemnity (Income) Dispute Resolution if you disagree with the insurance carrier regarding income benefits. The law provides that your dispute proceedings will be held within 75 miles from your residence.

7. **You have the right to choose a treating doctor.**
   If you are in a Workers' Compensation Health Care Network (network), you must choose your doctor from the network's treating doctor list. You may change your treating doctor once without network approval. If you are not in a network, you may initially choose any doctor who is willing to treat your workers' compensation injury; however,

changing your treating doctor must be pre-approved by the DWC if you are not in a network. If you are employed by a political subdivision (e.g. city, county, school district,) you must follow its rules for choosing a treating doctor. It is important to follow all the rules in the workers' compensation system**. If you do not follow these rules, you may be held responsible for payment of medical bills.** OIEC staff can help you to understand these rules.

8. **You have the right for your workers' compensation claim information to be kept confidential.**
   In most cases, the contents of your claim file cannot be obtained by others. Some parties have a right to know what is in your claim file, such as your employer or your employer's insurance carrier. Also, an employer that is considering hiring you may get limited information about your claim from DWC.

Your Responsibilities in the Texas Workers' Compensation System

1. **You have the responsibility to tell your employer if you have been injured at work while performing the duties of your job. You must tell your employer within 30 days of the date you were injured or first knew your injury or illness might be work-related.**

2. **You have the responsibility to know if you are in a Workers' Compensation Health Care Network (network).**
   If you do not know whether you are in a network, ask the employer you worked for at the time of your injury. If you are in a network, you have the responsibility to follow the network rules. If there is something you do not understand, ask your employer or call OIEC. If you would like to file a complaint about a network, call TDI's Customer Help Line at 1-800-252-3439 or file a complaint online at http://www.tdi.texas.gov/consumer/complfrm.html#wc.

3. **If you worked for a political subdivision (e.g., city, county, school district) at the time of your injury, you have the responsibility to find out how to receive medical treatment.**
   Your employer should be able to provide you with the information you will need in order to determine which health care providers can treat you for your workplace injury.

4. **You have the responsibility to tell your doctor how you were injured and whether the injury is work-related.**

5. **You have the responsibility to send a completed Employee's Claim for Compensation for a Work-Related Injury or Occupational Claim Form (DWC041) to DWC.**
   You have one year to send the form after you were injured or first knew that your illness might be work-related. Send the completed DWC041 form even if you already are receiving benefits. You may lose your right to benefits if you do not timely send the completed claim form to DWC. For a copy of the DWC041 form you may contact DWC or OIEC.

6. **You have the responsibility to provide your current address, telephone number, and employer information to DWC and the insurance carrier. DWC can be contacted at 1-800-252-7031.**

7. **You have the responsibility to tell DWC and the insurance carrier anytime there is a change in your employment status or wages.** (Examples of changes include: you stop working because of your injury; you start working; or you are offered a job).

8. **Eligible beneficiaries or persons seeking death and burial benefits have the responsibility to send a completed Beneficiary Claim for Death Benefits (DWC-042) to DWC within one year following the employee's date of death.**

9. **You are prohibited from making frivolous or fraudulent claims or demands.**

Optimum care™

All employees are permitted by the Workers' Compensation Act to choose any doctor that accepts workers' compensation insurance. **Optimum Care** physicians and facilities are pre-screened based on several quality indicators and are experienced in treating work-related injuries. These providers have agreed to treat your compensable work-related injury in the timeliest manner.

If you are injured at work...

- **In emergencies, call 911 and seek immediate treatment from the nearest qualified facility or provider.**
- Notify your immediate supervisor that an injury has occurred.
- If you require non-emergency-related medical attention, we have made arrangements with the pre-approved providers listed below.
- For urgent care needs after clinic hours, you may proceed directly to the nearest hospital emergency room.

Approved Physicians:

Concentra
8756 Teel Parkway, Ste. 350
Frisco, TX 75034
972.712.5454

Care Now
301 West Main Street
Frisco, TX 75034
972.335.0030

Care Now
5644 Preston Road
Frisco, TX 75035
972.529.4545

Legacy ER
9205 Legacy Drive
Frisco, TX 75034
972.668.6020

Legacy ER
16151 Eldorado Pkwy
Frisco, TX 75035
972.731.5151

Optimum Care is NOT a Certified Network

For questions regarding your claim or if you need an alternative to the providers listed here, please contact:

800.765.2412