Catholic Diocese of Sioux Falls

Workers' Compensation

The Catholic Diocese of Sioux Falls is insured for Workers' Compensation with **First Dakota Indemnity (RAS – Risk Administration Services).** Our Workers' Compensation Insurance Agency (Agents) is/are Marsh McLennan Agency. *Our Policy Number is WC02000767962024A*

If/when there is a work related incident or injury, please refer to the Catholic Diocese of Sioux Falls ***"Workers' Compensation Grab-N-Go" kit/folder.***

If you receive questions pertaining to a claim number/policy number or where to send bills:

First Dakota Indemnity (RAS): Policy Number WC02000767962024A
Claim Verification & Billing Questions: (877-585-1117) 8:00am -5:00pm CDT (M-F)
Bills & Notes Fax: 877-884-6573
Billing Address: Risk Administration Services
PO Box 89310
Sioux Falls, SD 57109-9310
Electronic Bill Submission:
Payor ID: CB293
Clearinghouse: WorkCompEDI
Contact WorkCompEDI to setup electronic billing: nassco@workcompedi.com
Phone: 800-297-6909

If you need/require additional assistance/direction, please feel free to contact our Claims Advocate at Marsh McLennan Agency:

Tanya D. Schlenker, CISR/SDWCS
Risk Management Strategist / Claims Advocate
Office/Cell: (605)366-1841 (24/7)
Tanya.schlenker@marshmma.com
***If you are unable to reach Tanya directly, please leave a voice mail for a return call, or if an emergency, please call (605)339-3874.*

Marsh McLennan Agents/Representatives
Allen Schlenker, Risk Management Consultant | 605-274-7134 allen.schlenker@marshmma.com
Tracy Skuza, Client Executive | 605-274-7183| tracy.skuza@marshmma.com
Tammy Carlson | 605-274-7179 | tammy.carlson@marshmma.com
Tanya Schlenker | 605-366-1841 | tanya.schlenker@marshmma.com

RISK ADMINISTRATION SERVICES, INC.

SOUTH DAKOTA
CLAIMS KIT

Thank you for choosing RAS for all your workers' compensation needs. Enclosed you will find documentation necessary for the processing and administration in the event of a workers' compensation claim.

WORKERS' COMPENSATION.
It's what we do. It's who we are.

INCLUDED IN THIS PACKET

- ✓ Injury Reporting Options
- ✓ First Report of Injury **DLR-LM-101**
- ✓ First Fill Instructions for RAS
- ✓ Medical Authorization Form
- ✓ Employee Injury Report
- ✓ Supervisor's Report of Injury
- ✓ Return to Work Form
- ✓ SD Employee Workers Compensation Notice

FIRST AID – ONSITE TREATMENT ONLY CHECKLIST

NO OUTSIDE MEDICAL TREATMENT SOUGHT

This checklist is for managers to use for employees who have had an incident/injury, but the employee does not require or want to seek outside medical treatment with a physician or medical provider.

AFTER the scene of the accident has been secured:

☐ 1) Ask the employee to complete the **"Employee Injury Report"** form.
   A. This document must be completed in detail. The person reading it should be able to tell exactly how and what happened. Be specific with your answers. (Write facts, not opinions)
   B. Make sure the form is signed and dated by the employee.

☐ 2) Complete the **"Supervisor's Report of Accident**" form.
   A. Be sure to note any "weather" conditions that may have contributed to the injury, and where the hazard is located and take pictures of the accident scene as soon as you can after the injury has occurred if possible.
   B. Note if the injury was due to a faulty/damaged tool, object, etc. and if so, keep that item as it could be considered evidence if the incident develops into a claim.

☐ 3) Advise the employee *that if they wish to seek treatment at a later date as it pertains to this incident, they must IMMEDIATELY notify you*, at which time the "Seeking Treatment" process will begin and a First Report of Injury will be completed/filed with the Work Comp Insurance Carrier and/or WC Agent.

☐ 4) **Send completed Employee Injury Report and Supervisors Report of Accident to Diocesan HR Office via the shared drive.**

☐ 5) Follow-up with the employee on a weekly basis asking "How they are doing/feeling" etc.

If you have questions, please call or email the Diocesan HR Office:

Renee Leach at 605-988-3752 / rleach@sfcatholic.org or Twila Roman at 605-988-3741 / troman@sfcatholic.org)

WORKERS' COMPENSATION CHECKLIST

FIRST REPORT OF INJURY – EMPLOYEE SEEKING TREATMENT

This checklist is for managers to use for employees who wish to seek outside medical treatment with a physician or medical provider.

AFTER the scene of the accident has been secured:

- ☐ 1) **Call the Catholic Diocese HR Office immediately**:
  Renee Leach at (605)988-3752 or Twila Roman at (605)988-3741

- ☐ 2) Ask the employee to complete the **"Employee Injury Report Form"**.

- ☐ 3) Ask the employee to read and sign "**Authorization for Use or Disclosure of Protected Health Information Form"**.

- ☐ 4) Complete **"Supervisors Report of Accident".** This document must be completed in detail. The person reading it should be able to tell exactly how and what happened.

  A. Be **specific** with your answers.
  B. Write facts**,** not opinion.
  C. Note the body part injured.
     - Right or Left? Low Back or Upper Back? Neck or Shoulder etc.
     - Where exactly on the body part? Upper Rt arm, Lower Rt arm, etc.
  D. Be sure to note any "weather" conditions that may have contributed to the injury, and where the hazard is located.
  E. Note if the injury was due to a faulty/damaged tool, object, etc.

- ☐ 5) Use the "Employee Injury Report Form" and "Supervisors Report of Accident" to complete the **"First Report of Injury"** form**.**

  A. Be specific with your answers.
  B. Note the body part injured
  C. Be sure the employee signs and dates the *Employee Section* of the form.

- ☐ 6) Ask the employee to read and sign the "**South Dakota Employee Worker's Compensation Notice"**.

- ☐ 7) Provide the employee with the "**First Fill Instructions for RAS"** form and the "**Your Work Comp Information"** sheet.

- ☐ 8) Provide the employee with the "**Return to Work Report"** Form and notify them that it needs to be completed by the physician and returned to you after each treatment or appointment unless they are admitted to the hospital.

- ☐ 9) Place the completed forms in the shared folder and notify the Diocesan HR Office that they are ready to be processed.

Checklist for the Injured Employee

This checklist is for employees to use as they report a work related incident/injury.

Immediately notify your employer of any work related injury or incident. State law requires that you give written notice of an injury to your employer within THREE (3) business days.

***First aid only - If you do not need outside medical treatment*:**

☐ 1) Your employer will ask you to complete an **"Employee Injury Report"** form as soon as you are able.
   A. This document must be completed in detail. Provide specific details about exactly how and what happened.
   B. Be specific with your answers. (Write facts, not opinions)
   C. Make sure the form is signed and dated.

☐ 2) If you wish to seek treatment later as it pertains to this injury, you must notify your supervisor immediately in order to complete the necessary paperwork to submit a claim.

***If you choose to seek treatment right away*:**

☐ 3) Your employer will ask you to complete and sign several forms to start the claim process;
   a. Employee Injury Report
   b. Authorization for Use or Disclosure of Protected Health Information
   c. First Report of Injury
   d. SD Employee Worker's Compensation Notice

4) Your employer will provide you with a Return to Work Report form. A copy of this form must be taken to every doctor's appointment you attend to be signed by the physician and returned to your supervisor.

5) Your employer will provide you with Work Comp claim information to provide to your doctor and pharmacist for bill payments and treatment preauthorization.

6) Please be aware of your rights and responsibilities under SDCL 62-4-43

   a) Reasonable and necessary medical care will be paid for any compensable work injury. Medically authorized time away from work will be reimbursed in accordance with the State of South Dakota workers' compensation laws. Wherever possible light duty restrictions imposed as a result of your injury will be accommodated.

   b) You may make the initial selection of a medical doctor or surgeon from among all licensed medical practitioners or surgeons in the state. You must notify your supervisor/employer of your choice of medical doctor/surgeon prior to seeking treatment, or immediately thereafter. This statute also places limitations on your right to

change primary health care providers. Discuss with your employer/carrier any change in health care provider.

c) You must attend all scheduled appointments. While on physical limitations, visits should be a minimum of once every two weeks, unless otherwise indicated/explained by your treating physician. Failure to have current medical support for disability may result in termination of benefits. Schedule your next appointment immediately after your doctor's visit, before you leave the clinic if possible.

d) Obtain a signed Return to Work Report from your physician at every appointment. State law requires that your physician cooperate with providing information regarding your injury, which under our policy includes return to work planning and that you be released to return to work at the earliest appropriate time.

e) Immediately following your appointment, provide a copy of the Return to Work Report to your Supervisor. You should deliver this in person if possible, so that changes in work restrictions may be addressed and any questions answered. If you are unable to provide a copy in person, the Return to Work Report should be emailed or texted as soon as possible.

f) Follow all physical restrictions at home AND at work.

g) Report to work and perform physically suitable tasks as assigned. These may or may not be in your regular department. The work may or may not be on your usual shift.

h) Maintain regular, weekly communication with your supervisor if you are unable to return to work. Contact your supervisor a minimum of after every visit with your primary health care provider. Keep the claims representative advised of your status.

i) Notify your supervisor immediately of any new injuries or conditions that impact your physical condition.

j) If it is necessary to miss scheduled work due to your work injury, you must be seen by your primary health care provider the same day. The physician must complete and sign a Return to Work Report.

South Dakota Employer's First Report of Injury

EMPLOYEE

SSN: _____ Date of Birth: _____ Gender: M ◯ F ◯ Dependents: _____

Name: (Last) _____ (First) _____ (Middle initial) ___

Mailing Address: _____

City: _____ State: _____ Zip: _____ Telephone No.: _____

Employee signature: (X) _____ Date _____

Education:

☐ Less than High School

☐ GED or High School

☐ Beyond High School

INJURY/TREATMENT

Date of Injury: _____ Time of Injury: _____ a.m. ☐ p.m. ☐ Fatality Date (if applicable): _____

County Where Injury Occurred _____ Was Safety Equipment Provided? Yes ☐ or No ☐

Time Work Day Began on Date of Injury: _____ a.m. ☐ p.m. ☐ Was Safety Equipment Used? Yes ☐ or No ☐

Date Returned to Work (if applicable): _____ Did Injury Occur on Employer Premises? Yes ☐ or No ☐

Address or Location of Injury: _____

Description of Injury:

Date Employer Notified of Injury: _____

Injury Reported to: _____ Witness: _____

(See Codes on Second Page)

Body Part Injured

(If code 90, Multiple Injury, please specify body part codes for each body part injured.)

Nature of Injury

Cause of Injury

Type of Treatment (please check one)

☐ No Treatment

☐ On-Site Treatment

☐ Clinic

☐ Emergency Room

☐ Hospitalization

If treatment sought, please specify provider of treatment:

Medical Practitioner, Clinic or Hospital Name: _____

Mailing Address: _____

City: _____ State _____ Zip _____

Telephone No. : _____

EMPLOYER/EMPLOYMENT INFORMATION:

Federal ID No.: _____ # Employees: _____

Employer Name (DBA): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone No. : _____ County Where Employer Located: _____

Employer signature: _____ Date _____

Employment Type: ☐ Regular or ☐ Temporary

Emp. Status: ☐ FT ☐ PT ☐ Seasonal ☐ Volunteer

Date Employee Hired: _____

Employee's Position: _____

Employee's Time in Current Position: _____

Employee's Hours Per Week: _____

Employee's Current Wage:

$ _____ per _____

CLAIM OFFICE INFORMATION

NAICS for Employer Being Insured (Nature of Business): _____

Carrier Code _____ FEIN (Claim Office) _____

Claim Office _____

Claim Office Address _____

City _____ State _____ ZipCode _____

Telephone _____

Email Address _____

Claim Office Claim # _____

Date Notified _____ Date to DOL _____

☐ Check if Claim Office is same as Insurance Provider

If not, you must complete the following

UNDERLYING INSURANCE PROVIDER INFORMATION

Carrier Code (If applicable) _____ FEIN (Insurance Provider) _____

Represented Entity Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone Number _____

Policy Number _____

Effective Dates _____

Adjuster/Contact Person _____

For information regarding the Workers' Compensation System please visit www.sdjobs.org

DLR-LM-101 Revised 11/2018

SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION

DIVISION OF LABOR AND MANAGEMENT

Tel: 605.773.3681 dlr.sd.gov

FIRST REPORT OF INJURY

GENERAL INSTRUCTIONS

EMPLOYEE

1. Notify employer immediately of injury, as required by SDCL 62-7-10.
2. Complete all questions in the EMPLOYEE and INJURY/TREATMENT sections.
3. Sign the form.
4. Submit this form to your employer within three (3) business days after the injury.

EMPLOYER

1. Complete all questions in the EMPLOYER/EMPLOYMENT sections.
2. Sign the form.
3. Submit this form to your workers' compensation insurance carrier within seven (7) days of knowledge of the occurrence of the injury, as required by SDCL 62-6-2.
4. Give a copy of the form to the injured employee.
5. Keep the copy of the First Report of Injury for at least four (4) years from the date of injury, as required by SDCL 62-6-1.

BODY PART CODES

02	Blindness one eye	44	Chest, including ribs sternum, soft ribs	78	Ring finger at metacarpal bone
03	Blindness both eyes	48	Internal organs-other than heart, lungs	79	Ring finger at proximal joint
04	Deafness both ears	49	Heart	80	Ring finger at middle joint
05	Deafness one ear	51	Hip	81	Ring finger at distal joint
10	Multiple head injury	52	Upper leg	82	Little finger at metacarpal bone
11	Skull	53	Knee	83	Little finger at proximal joint
12	Brain	54	Lower leg	84	Little finger at middle joint
13	Ear(s)	55	Ankle	85	Little finger at distal joint
14	Eye(s)	56	Foot	86	Great toe metatarsal bone
17	Mouth	57	Toe (other than greater)	87	Great toe at proximal joint
19	Face (facial bones)	58	Toe (greater)	88	Great toe at distal joint
20	Multiple neck injury	60	Lungs	90	Multiple injury
21	Vertebrae	61	Groin	92	Other toe metatarsal bone
22	Disc	67	Thumb metacarpal bone	93	Other toe at proximal joint
24	Other	68	Thumb at proximal joint	94	Other toe at middle joint
31	Upper arm	69	Thumb at distal joint	95	Other toe at distal joint
32	Elbow	70	Index finger at metacarpal bone	96	Little toe metatarsal bone
33	Lower Arm-forearm	71	Index finger at proximal joint	97	Little toe at distal joint
34	Wrist	72	Index finger at middle joint		
35	Hand	73	Index finger at distal joint		
37	Thumb	74	Middle finger at metacarpal bone		
38	Shoulder	75	Middle finger at proximal joint		
41	Upper Back	76	Middle finger at middle joint		
42	Lower Back	77	Middle finger at distal joint		

Cause of Injury Codes

01	Body reaction/over reaction (includes chemicals)	70	Striking against or stepping on
03	Temperature extremes	78	Struck or injured by moving parts of machine
13	Caught in/under/between	81	Struck or injured, includes knife or sharp object, kicked, bit, etc. – struck by object, worker, patient, etc.
25	Fall from elevation	89	Hostile attack-person in act of crime
29	Fall from same level	90	Other than physical cause of injury
50	Motor vehicle	94	Repetitive motion – callous, blister, etc.
56	Bending/Lifting	97	Repetitive motion-carpal tunnel syndrome, etc.
65	Machinery/Equipment	99	Other

Nature of injury codes

00	Not applicable
01	Allergy
02	Disfigurement
71	Occupational disease
72	Hearing loss

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.

RISK ADMINISTRATION SERVICES, INC.

YOUR WORK COMP INFORMATION

This document acts as your Identification Card for your workers' compensation claim. It is important to present this document upon arrival to any medical provider that is treating you for your work-related illness or injury. If you have any questions, please contact your employer or RAS.

This document was created on _____ **for** _____ **only and does not certify compensability or guarantee coverage.**
Date Claim Number

CLAIM INFORMATION

Claim Number:

Carrier:

Jurisdiction:

Patient's Name:

Date of Injury:

PHARMACY INFORMATION

RxBIN:	610729
RxPCN:	ALIUS
Group #:	ALHFF1320216999
Member ID:	ALIUSyymmdd1234 (DOB and last 4 digits of SSN)
Person Code:	01

To locate additional pharmacies or to get an authorization for your medication, please contact 800.547.3330 or visit the website at
https://rascompanies.com/resources/

The pharmacy benefit card is only to be used for medications prescribed for your work-related injury. In using the card, you acknowledge and accept financial responsibility for any prescriptions billed under this card that are later found to be unrelated to your injury.
Generics should always be considered as the first line agents for prescribing

PROVIDER INFORMATION

Patient is seeking treatment under Workers' Compensation. Please include claim number and insurance plan/group on each bill for this injury and submit for payment as shown.

ELECTRONIC BILL SUBMISSION:
Payor ID: CB293
Clearinghouse: WorkCompEDI
Contact WorkCompEDI to setup electronic billing.
nassco@workcompedi.com
P. 800.297.6909

PAPER BILL SUBMISSION:
RAS
PO Box 89310
Sioux Falls, SD 57109-9310
Contact RAS for submission or billing questions.
P. 877.585.1117
F. 877.884.6573

Modified Duty is available. Please provide physical capabilities for injured employee and fax to RAS at 877.884.6573.

Visit https://rascompanies.com/resources/ to locate additional medical providers.

SERVICES INFORMATION

The following services must be pre-authorized by RAS. Please contact RAS at 800.732.1486 for any of the following procedures:

- Non-emergency hospitalizations, surgeries, outpatient surgery and transfers
- Physician Referral for specialized care or treatment
- Chiropractic treatment
- Physical Therapy
- Work hardening or Work conditioning programs
- Home Health Care
- Imaging/Diagnostic Studies (CT, MRI, bone scan, myelogram, discogram, EMG)
- Facet, Trigger Point or Epidural Steroid Injections
- Bone Growth Stimulators
- Durable Medical Equipment (DME)
- Request for unusual procedures
- Second Surgical Opinions

Please utilize the vendors below if onsite services are unavailable.

Durable Medical Equipment
PRN Solutions
E. ras@prn4hme.com | P. 800.776.5192 | www.prn4hme.com

Diagnostic Imaging (MRI, CT, EMG)
Absolute Solutions
P. 800.321.5040 | www.absolutedx.com

Home Health
PRN Solutions
E. ras@prn4hme.com | P. 800.776.5192 | www.prn4hme.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.

CORPORATE OFFICE IN SIOUX FALLS, SD
OFFICES IN EAGAN, MN · OMAHA, NE · LAS VEGAS, NV

MAIL: PO Box 89310, Sioux Falls, SD 57109-9310
P. 800.732.1486 F. 877.884.6573
RASCompanies.com

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:**

CORPORATE OFFICE IN SIOUX FALLS, SD
OFFICES IN EAGAN, MN · OMAHA, NE · LAS VEGAS, NV

MAIL: PO Box 89310, Sioux Falls, SD 57109-9310
P. 800.732.1486 F. 877.884.6573

RASCompanies.com

RISK ADMINISTRATION SERVICES, INC.

SUPERVISOR'S REPORT OF ACCIDENT

The primary purpose of the SRA is to investigate the accident. It is also used to report the accident to the central office where the First Report of Injury is then completed by administrative personnel. The SRA should be filled out as soon as possible after the accident.

Every accident should be investigated, and the causes corrected so that more accidents will not occur. Do not overlook the so-called "unimportant' cases, because, except for "chance" they could also have been serious. It is only by thorough investigation that many of the real causes can be determined and corrected. *This report should not be completed by the injured employee*.

INJURED WORKER			
Name of Employee:	Company:	Department:	Date of Accident:
Time:	Did Employee lose time from work? ☐ **Yes** ☐ **No**	Hours lost on date of accident:	Has employee returned to work: ☐ **Yes** ☐ **No**
Job Title:	Service with the Company:	Years in present job:	

SAFETY QUESTIONS

1. Was injured person properly instructed in safe and efficient methods? ☐ **Yes** ☐ **No**

Supervisors should instruct their employees on how to do the job efficiently and safely.

2. Did injured person violate any instructions? ☐ **Yes** ☐ **No**

What was the violation?

3. Was necessary protective equipment worn? (if applicable) ☐ **Yes** ☐ **No**

The supervisor should have told the employee what personal protective equipment is necessary to do the job. Did the employee wear the personal protective equipment when this job was being done?

4. Did poor housekeeping contribute to injury? ☐ **Yes** ☐ **No**

Was the work area clean and well organized? i.e., scraps on the floor, blocked aisles, wet floor, spilled food, etc.

5. Did horseplay cause the injury? ☐ **Yes** ☐ **No**

Was there inadequate supervision? Did horseplay or practical jokes contribute to the accident?

6. Was it caused by something that needed repairs? ☐ **Yes** ☐ **No**

i.e., broken ladder, bad electric cord on drill, etc.

7. Should a guard be provided? ☐ **Yes** ☐ **No**

i.e., guard around the belts and pulleys, railing properly in place, guard on saw, etc.

8. Did any bodily defect contribute to injury? ☐ **Yes** ☐ **No**

i.e., poor vision, previous back injury, etc.

9. Was it caused by an unsafe act? ☐ **Yes** ☐ **No**

Most injuries are caused in part by unsafe acts. An Unsafe Act is something that the injured person or another person did, that he or she should not have done, which led to the accident. Below is a list of the most common unsafe acts and contributing factors:

1. Operating without authority
2. Failure to warn or secure
3. Operating at unsafe speed
4. Making safety devices in-operative
5. Using equipment, tools, materials or vehicles unsafely
6. Using defective equipment, materials, tools or vehicles
7. Failure to use personal protective equipment
8. Failure to use equipment provided (except personal protective equipment)
9. Unsafe loading, placing and mixing
10. Unsafe lifting and carrying (including insecure grip)
11. Taking an unsafe position
12. Adjusting, clearing jams, cleaning machinery in motion
13. Distracting, teasing
14. Poor housekeeping practices
15. Disregard of instructions
16. Lack of knowledge or skill
17. Action of other than injured
18. Others…

10. Did injured report the injury to you, the supervisor, immediately? ☐ **Yes** ☐ **No**

Continued on next page

ACCIDENT INFORMATION

Accident – Describe what injured was doing at time of accident, what happened, who was involved, nature of injury, part of body affected. *Example: John was drilling a hole in the ceiling and chips of plaster fell into his eye.*

Witnesses' Names:

Unsafe Acts – What did the employee or another person do incorrectly?
Refer to Question 9 above and examples of Unsafe Acts. Example: John was not wearing proper personal protective equipment.

UNSAFE CONDITIONS

1. Defective tools, equipment, substances
2. Unsafe design or construction
3. Hazardous arrangement
4. Improper illumination
5. Improper ventilation
6. Improper dress
7. Poor housekeeping
8. Congested area
9. Other

Actions Taken – What did you do to correct the conditions which caused this accident?
Example – John has been re-instructed to wear proper personal protective equipment such as goggles or face shield when drilling overhead.

Remedies – What should your organization do to prevent other injuries like this?
Example – Standard safety policy should be adopted that requires use of personal protective equipment. This policy should be strictly enforced by the supervisors.

MEDICAL CARE

Did employee go to doctor or hospital? ☐ **Yes** ☐ **No** **If yes please complete the following below**

Date of Initial Visit:	Name of Doctor or Hospital:	Address:	Phone:

As a supervisor, do you feel that this injury should be covered under Workers' Compensation? ☐ **Yes** ☐ **No**

Report Submitted by: **(Name and Title)**	Date:

CORPORATE OFFICE IN SIOUX FALLS, SD
OFFICES IN EAGAN, MN · OMAHA, NE · LAS VEGAS, NV

MAIL: PO Box 89310, Sioux Falls, SD 57109-9310
P. 800.732.1486 F. 877.884.6573
RASCompanies.com

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:

CORPORATE OFFICE IN SIOUX FALLS, SD
OFFICES IN EAGAN, MN · OMAHA, NE · LAS VEGAS, NV

MAIL: PO Box 89310, Sioux Falls, SD 57109-9310
P. 800.732.1486 F. 877.884.6573

RASCompanies.com

RISK ADMINISTRATION SERVICES, INC.

SOUTH DAKOTA EMPLOYEE
WORKERS' COMPENSATION NOTICE

Claim No.: _____

Beginning July 1, 1994, the notice provision of South Dakota's Workers Compensation Act (SDCL 62-7-10) required employees to provide notice of all injuries for which they intend to claim the right to workers' compensation benefits no later than **THREE (3) business days** after the injury occurs. The notice must advise the employer when, where and how the injury occurred. Failure to provide notice could prohibit a claim for compensation.

In 1999, South Dakota Legislature authorized the formation of a State Fraud unit. This unit will investigate and prosecute insurance fraud.

Knowingly filing a fraudulent claim for workers' compensation benefits to an employer or Insurance company, under SDCL 62-4-51 of the South Dakota Workers' Compensation Act is considered a Class 1 misdemeanor.

A Class 1 misdemeanor, if convicted, carries a maximum penalty of a fine of not more than One Thousand Dollars ($1,000.00) or imprisonment in a county jail for a period of one year or both. In addition, the court may impose that the defendant make restitution.

By signing below, I acknowledge that I have read and understand the above two statements regarding filing a South Dakota Workers' Compensation injury claim.

X _____ _____

Employee Signature Date

X _____ _____

Supervisor 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