Together Achieving Team Excellence

COUNTY SCHOOL DISTRICT
COLDWATER • EAST TATE • INDEPENDENCE • STRAYHORN

Business office
574 Parkway Street
Coldwater, MS 38618
P (662)562-5861 F (662)622-7406
www.tatecountyschools.org

To: Tate County School District Employees

From: Sandy Patton, Business Manager

Date: October 1, 2020

RE: Worker Compensation Claim Forms

The attached documents must be completed when a Workers' Compensation claim is being filed

The **MWCC-Workers' Compensation – First Report of Injury or Illness form** should be e-mailed or faxed to the business office as soon after the incident occurs as possible. This document is needed to start the claim process with our insurance carrier This form should be taken with injured to the doctor's office because our insurance carrier's contact information and policy number is on this form.

Within three days of the incident the following forms must be sent to the business office:

1. First Report of Injury or Illness Form
2. Hand Written Statement from Witness Detailing the Accident

If you have any questions, please contact me at 662-562-5861 x1003 or by e-mail at spatton@tcsdms.org.

Thank you,

Sandy Patton

Sandy Patton

MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

TATE COUNTY SCHOOL DISTRICT
574 PARKWAY STREET
COLDWATER, MS 38618

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE # 662-562-5861

SIC CODE

EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)

Berkley Southeast Insurance Group
PO Box 5658
Meridian, MS 39302-5658
1-855-802-5273 Fax 1-866-814-7532

POLICY PERIOD 10/1/2021 TO 9/30/2022

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN

POLICY/SELF-INSURED NUMBER 4419864-42

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX
- MALE (M)
- FEMALE (F)
- UNKNOWN (U)

MARITAL STATUS
- UNMARRIED/SINGLE/DIVORCED (U)
- MARRIED (M)
- SEPARATED (S)
- UNKNOWN (K)

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

OF DEPENDENTS

NCCI CLASS CODE

RATE PER: DAY / WEEK / MONTH / OTHER:

#DAYS WORKED WEEK

FULL PAY FOR DAY OF INJURY? YES NO

DID SALARY CONTINUE? YES NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK AM / PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE AM / PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? YES NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? YES NO

WERE THEY USED? YES NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT
- NO MEDICAL TREATMENT (0)
- MINOR: BY EMPLOYER (1)
- MINOR CLINIC/HOSP (2)
- EMERGENCY CARE (3)
- HOSPITALIZED > 24 HRS (4)
- FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5)

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

SEE BACK FOR INSTRUCTIONS

WORKERS' COMPENSATION - FIRST REPORT OF INJURY EMPLOYER'S INSTRUCTIONS

GENERAL INFORMATION

EMPLOYER (NAME & ADDRESS INCL ZIP) - The name and address of the entity employing or statutorily responsible for the employee.

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

EMPLOYER FEIN - Employer's Federal Employer Identification Number.

CARRIER/ADMINISTRATOR CLAIM NUMBER - Carrier's claim or file number.

REPORT PURPOSE CODE - A code used with Electronic Data Interchange to define the specific purpose of the report. (Original, Cancel, Change, Correction)

JURISDICTION - State in which you are filing the claim (Mississippi).

JURISDICTION CLAIM NUMBER - Number assigned to claim by Mississippi Workers' Compensation Commission (to be completed by MWCC).

INSURED REPORT NUMBER - The number, if any, used by the employer to identify the claim.

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) - The name and address of the employer's facility where the employee was employed at the time of injury, if different from above.

LOCATION #/ PHONE # - The number, if any, assigned by the employer to identify its location where the injury occurred and the phone number.

CARRIER (NAME, ADDRESS & PHONE NO) - The licensed business entity issuing the contract of insurance and assuming financial responsibility for the claim on behalf of the employer.

POLICY PERIOD - The date that the contract/policy under which the claim occurred began and expired.

CHECK IF APPROPRIATE (SELF-INSURANCE) - An indicator that identifies the employer as one who retains the risks arising from their operations and bears the financial responsibility. A jurisdictionally approved or acknowledged employer, group fund, or association assuming financial risk and responsibility for their employee's worker's compensation claims.

CLAIMS ADMINISTRATOR - The business entity providing claim services on behalf of the carrier, or self-insured. The name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

CARRIER FEIN - Carrier's Federal Employer Identification Number.

POLICY/ SELF-INSURED NUMBER - The number assigned by the carrier to the insurance contract/policy for the employer, or any similar number assigned to a self-insured employer.

ADMINISTRATOR FEIN - Federal Employer Identification Number of Administrator.

AGENT NAME & CODE NUMBER - The name of the insurance agent and the agent's code number if known. This information should be found in the insurance policy.

EMPLOYEE/WAGE INFORMATION

NAME (LAST, FIRST MIDDLE) - Employee's legally recognized name.

ADDRESS - The mailing address used by the employee.

PHONE - A telephone number where the employee can be reached.

DATE OF BIRTH - The date the employee was born.

SOCIAL SECURITY NUMBER - A number assigned by the Social Security Administration used to identify the employee.

DATE HIRED - The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.

STATE OF HIRE - State where employee was hired.

SEX - The code which indicates the sex of the employee.

MARITAL STATUS - The code which indicates the marital status of the employee.

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

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

NCCI CLASS CODE - A code which corresponds to the primary occupation which the employee was engaged at the time of accident/injury, or injurious exposure. Codes are found in the NCCI BASIC MANUAL FOR WORKERS' COMPENSATION AND EMPLOYERS LIABILITY INSURANCE.

RATE - The reported employee's wage rate at the time of injury.

 # DAYS WORKED/ WEEK - The number of days worked by the employee in a week.

FULL PAY FOR DAY OF INJURY - State whether employee was paid his full wages on the injury date.

DID SALARY CONTINUE - State whether employee's salary was continued by the employer in lieu of compensation benefits.

OCCURRENCE/TREATMENT INFORMATION

TIME EMPLOYEE BEGAN WORK - The time employee began work on date of injury.

DATE OF INJURY/ILLNESS - The date employee was injured.

TIME OF OCCURRENCE - The time employee was injured.

LAST WORK DATE - The date employee last worked following the injury.

DATE EMPLOYER NOTIFIED - The date on which the employer was notified of the injury.

DATE DISABILITY BEGAN - The date on which employee began losing time.

CONTACT NAME/PHONE NUMBER - Name and phone number of employer representative to be contacted for further information.

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

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

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES - Mark yes or no as applicable.

TYPE OF INJURY/ILLNESS CODE - The NCCI code which corresponds to the nature of the injury or illness. (NCCI Table 8: Nature of Injury Codes)

PART OF BODY AFFECTED CODE - The NCCI code which corresponds to the part of the body injured. (NCCI Table 7: Part of Body Codes)

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED - The county where the injury occurred. If the injury did **not** occur in Mississippi, put "out of state".

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED - List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint. Enter "NA" for not applicable if no equipment, materials, or chemicals were being used.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED - Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

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

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED, DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL - Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

CAUSE OF INJURY CODE - The NCCI code which identifies the cause of injury. (NCCI Table 9: Cause of Injury Codes)

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

IF FATAL, GIVE DATE OF DEATH - Date of death of employee.

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED/WERE THEY USED - Check applicable "yes" or "no" box.

PHYSICIAN/HEALTH CARE PROVIDER (NAME AND ADDRESS) - The name and address of the physician or health care professional providing initial treatment.

HOSPITAL (NAME AND ADDRESS) - The name and address of the hospital where employee was treated (if applicable).

INITIAL TREATMENT - Check applicable choices.

WITNESSES (NAME & PHONE #) - The name(s) and phone number(s) of any one who witnessed the accident.

DATE ADMINISTRATOR NOTIFIED - The date the carrier or claims administrator processing the claim received notice of the injury.

DATE PREPARED - The date this report was prepared.

PREPARER'S NAME & TITLE - The name and title of the person who prepared this report.

PHONE NUMBER - The phone number of the person who prepared this report.

Berkley Southeast Insurance Group
a Berkley Company

SmithRx
Pharmacy Benefits. Simplified.

Prescription Benefits Information For Your Workers' Compensation Claim

Welcome to SmithRx.

Your employer's workers compensation carrier has chosen SmithRx to provide pharmacy benefits for their injured workers. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy.

What do I need to do?

If you need a prescription filled for a work-related injury or illness, visit an in-network pharmacy and provide this card to the pharmacist. The pharmacist will fill your prescription at no cost to you.

May I fill prescriptions at my usual pharmacy?

Most pharmacies, including all major chains, are included in this network. To find or inquire about a network pharmacy and whether your preferred pharmacy is included, please call **(844) 414-0701**.

Is this my permanent card?

This card is valid for one-time use. You have 7 days from the date your injury was reported to utilize this card. If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Once you receive it, please use the permanent card going forward.

Your Temporary Pharmacy Benefits Card

Berkley Southeast Insurance Group

SmithRx

SmithRx is the designated PBM for this patient

Employer: _____

First Name: _____ Last Name: _____

Social Security Number: Please provide directly to Pharmacist

Date of Injury: _____

Note to Cardholder:
Present this card to the pharmacy to receive medication for your work related injury

Note to Pharmacists:
ENTER RxBIN, RxPCN, and GROUP

MEMBER ID # FORMAT IS DATE OF INJURY AND SSN COMBINED AS FOLLOWS: YYMMDD123456789

IF NO SSN, ALL 9s CAN BE USED

Pharmacist Support
844-414-0703

Rx Bin 019025
Rx PCN 8001002
Rx Group BSIGFF

Note: Your use of this workers compensation pharmacy benefits card is limited to those prescriptions medically related to a workers compensation injury (covered under applicable state workers compensation regulations).

Questions? Call 844-414-0701

Berkley Southeast Insurance Group
a Berkley Company

Claims Information Flyer

Options to Report New Losses to Berkley Southeast Insurance Group (BSIG):

1. Contact your local agent
2. Phone us 24/7/365:
   - All losses except auto glass: 1(855) 802-5273
   - Auto glass-only losses: 1(800) 452-7449 *(and you can schedule your repairs today!)*
3. Report your loss on-line 24/7/365: REPORT LOSS ON-LINE LINK
4. Email us your loss info: newclaims@berkleysig.com
5. Fax us your loss info: 1(866) 814-7532

All claims material (other than new loss notices) should be mailed to the following:

All Workers Comp Medical Bills:
BSIG/CareWorks
PO Box 1290
Canonsburg, PA 15317

All other correspondence:
Berkley Southeast Insurance Group
PO Box 5658
Meridian, MS 39302-5658
Email: claimsmail@berkleysig.com

Claims Leadership Contacts:

Scott Jurek, VP Claims	sjurek@berkleysig.com	Phone: (678) 533-3407
Christopher Calloway, WC Director	ccalloway@berkleysig.com	Phone: (678) 533-3418
Steve Klayman , Auto Manager	sklayman@berkleysig.com	Phone: (678) 533-3424
Jim Suppes, Quality & Ops. Director	jsuppes@berkleysig.com	Phone: (678) 533-3413
Brian Philipovich, Major Case Unit Mgr	bphilipovich@berkleysig.com	Phone: (704) 759-7006
Tyler Duggins, GL/Property Mgr.	tduggins@berkleysig.com	Phone: (678) 533-3447

Site Links:

BSIG Claims Customer Page

Workers Compensation On-line Clams Info and Kits

Your Back-In-Business Insurance Company™

09/13/2018

Berkley Southeast

A W. R. Berkley Company

Tate County School District - Coldwater (38618)
(10/24/2018)

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

Berkley Southeast Insurance Group
1745 North Brown Road
Suite 400
Lawrenceville, GA 30043

Provided below is a list of workers' compensation medical providers in your area that treat work-related injuries.

In your state the employee can select the first physician for medical treatment, following an on-the-job injury, however, if a change of physician is requested you can direct the employee to a physician of your choice at that time.

The doctors listed below are part of a Provider Network that Berkley Southeast Insurance Group utilizes. They will provide appropriate treatment in order to return the employee to work as soon as it's safe to do so. Should you have an opportunity to direct utilizing these physicians will assure that your employee has access to quality care while enabling you to manage your workers' compensation claims.

Always, in case of a medical emergency, call 911 and/or utilize the nearest hospital emergency room. Advise the hospital/physicians that treatment is for a work related injury.

Name	Address	Scheduling	Area of Specialty
MedCall Advisors	Call Toll Free for Immediate Doctor Contact	855-963-3225	Telemedicine/Urgent Care
Affordable Medical Care LLC	900 E Commerce St Hernando, MS 38632	662-429-9111	Urgent Care
Prime Urgent Medical Clinic	176 Goodman Rd W Southaven, MS 38671	662-536-1020	Urgent Care
One Call PT Network	Call Toll Free for Closest Location	1-866-389-0211	Physical Therapy
One Call Chiro Network	Call Toll Free for Closest Location	1-866-389-0211	Chiropractic
One Call Care Management	Call Toll Free for Closest Location	1-800-872-2875	MRI

Workers Compensation Claims
P. O. Box 1290
Canonsburg, PA 15317
FAX 877-684-5484
855-802-5273

Berkley Southeast
a W. R. Berkley Company

Tate County School District - Sarah (38665)
(10/24/2018)

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MedCall Advisors	Call Toll Free for Immediate Doctor Contact	855-963-3225	Telemedicine/Urgent Care
Affordable Medical Care LLC	900 E Commerce St Hernando, MS 38632	662-429-9111	Occupational Medicine
Prime Urgent Medical Clinic	176 Goodman Rd W Southaven, MS 38671	662-536-1020	Occupational Medicine
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Tate County School District - Coldwater (38618)
10/24/2018

AVISO A LOS EMPLEADOS EN CASO DE LESIONES RELACIONADAS CON EL TRABAJO

Berkley Southeast Insurance Group
1745 North Brown Road
Suite 400
Lawrenceville, GA 30043

A continuatión se presenta una lista de la Indemnización de los trabajadores médicos en su area que se utilizan en el tratamiento de lesiones relacionadas con el trabajo.

En su estado puede dirigir un trabajador lesionado a una red médico, sin embargo, en el caso de una emergencia médica, llame al 911 y/o utilizer el servicio de urgencies del hospital más cercano. Asesorar al hospital o médico que el tratamiento es por una lesió o enfermedad relaelonada con el trabajo.

Los medicos mencionados son parte de una red de proveedores que Berkley seguros Grupo Suresie utiliza. Se pretende dar un rato adecuado con el fin de devolver el empleado a trabajar tan pronto como es seguro hacerlo. Utilizando estos médicos se aseguran que el empleado tiene acceso a una atención de calidad al mismo tiempo que le permiten gestionar sus reclamos de compensación a trabajadores.

Siempre, en caso de una emergencia médica, llame al 911 y/o utilizar la sala de emergencies del hospital más cercana. Asesorar a hospital/médicos de que el tratamiento es para un trabajo relacionado con la lesión.

Name	Address	Scheduling	Area of Specialty
MedCall Advisors	Call Toll Free for Immediate Doctor Contact	855-963-3225	Telemedicine/Urgent Care
Affordable Medical Care LLC	900 E Commerce St Hernando, MS 38632	662-429-9111	Urgent Care
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Tate County School District - Sarah (38665)
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