Sedgwick Claims Kit
Texas

P.O. Box 14779 | Lexington, KY 40512 | Toll Free: 866-738-9201 | Fax: 859-280-3275

Dear Insured:

We would like to welcome you as a policyholder of Republic Lloyds Insurance Company. Sedgwick is your Claims Administrator and we are pleased to be able to provide you with workers' compensation claims handling services. Please follow the below instructions for filing a new claim and note the claim kit attachment.

Where do I report a claim?

- **Phone:** **855-728-5277 (855-7ATLAS7) OR;**
- **Email:** 6200AtlasGeneralInsurance@sedgwickcms.com OR:
- **Fax:** 866-383-3296

Sedgwick Claim Kit Attachments

- Employer Rights and Responsibilities
- Employer's First Report of Injury or Illness (Form DWC-001)
- New Employee Notice – Must Be Posted - (English/Spanish)
- Employee Rights and Responsibilities – (English/Spanish)
- Employee's Claim Form (From DWC-041) (English & Spanish)
- Express Scripts First Fill Temporary Pharmacy Card

Need a loss run?

- **Email us:** Lossruns@atlas.us.com

Have more questions?

Contact the Atlas Customer Care Team @ Sedgwick - One of our friendly Client Services Associates will be happy to assist you.

- **Phone:** 866-738-9201
- **Email:** AtlasTeam@Sedgwickcms.com

We appreciate your business and believe that communication is critical for successful claims administration. We encourage you to contact us if you have any questions.

www.Atlas.us.com/claims

Employer Rights and Responsibilities

Information for Employers from the Division of Workers' Compensation

Workers' Compensation Insurance Coverage

Workers' compensation insurance coverage provides covered employees with income and medical benefits if they sustain a work-related injury or illness. Except as otherwise provided by law; Texas private employers can choose whether or not to provide workers' compensation insurance coverage for their employees. Except in cases of gross negligence or an intentional act or omission of the employer, workers' compensation insurance limits an employer's liability if an employee brings suit against the employer for damages. Certain building or construction employers who contract with governmental entities are required to provide workers' compensation coverage for each employee working on the public project. Some clients may also require their contractors to have workers' compensation insurance.

Providing Workers' Compensation Insurance

If employers choose to provide workers' compensation, they must do so in one of the following ways:

- purchase a workers' compensation insurance policy from an insurance company licensed by the Texas Department of Insurance (TDI) to sell the coverage in Texas;
- be certified by the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) to self-insure workers' compensation claims; or
- join a self-insurance group that has received a certificate of approval from the TDI.

Note: Political subdivisions may self-insure, buy coverage from insurance companies, or enter into inter-local agreements with other political subdivisions that self-insure.

EMPLOYER RIGHTS

Covered employers have the following rights:

- the right to contest the compensability of a workers' compensation claim if the insurance carrier accepts liability for payment of benefits;
- the right to be notified of a proposal to settle a claim or of any administrative or judicial proceeding related to resolution of a claim (after making a written request to the insurance carrier);
- the right to attend dispute resolution proceedings related to an employee's claim and present relevant evidence about the disputed issues;
- the right to report suspected fraud to the TDI-DWC or to the insurance carrier;
- the right to contest the failure of the insurance carrier to provide required accident prevention services; and
- the right to receive return-to-work coordination services as necessary to facilitate an employee's return to employment.

To dispute a workers' compensation claim, an employer may file the DWC Form-004, and the DWC Form-045, *Request to Schedule, Reschedule or Cancel a Benefit Review Conference (BRC),* which may be obtained from the TDI website at http://www.tdi.texas.gov/forms/form20employer.html or by calling 1-800-252-7031.

Non-Reimbursable Employer Payments

An employer is not entitled to and cannot seek reimbursement from the employee or insurance carrier if after a work-related injury or illness they voluntarily:

- continue to pay the injured employee's salary continuation; or
- pay the injured employee salary supplementation to supplement income benfits paid by the insurance carrier.

Employer Voluntary Payments of Benefits

An employer may voluntarily pay income or medical benefits to an employee during a period in which the insurance carrier has:

- contested compensability of the injury;
- contested liability for the injury; or
- has not completed its initial investigation of the injury. *Note:* an employer is only allowed to pay benefits in this situation for the first two weeks after the injury.

For reimbursement, the employer is required to timely report the injury to the insurance carrier and to let the insurance carrier know, within 7 days of beginning

For further assistance, call 1-800-252-7031 or visit

http://www.tdi.texas.gov/wc/employer/index.html

voluntary payments, that voluntary payments are being made. The insurance carrier is only required to reimburse the employer for the amount of benefits the insurance carrier would have paid. If the employer made payments in excess of what the insurance carrier would have paid, the excess amount is not reimbursable, unless there is a written agreement between the injured employee and the employer that the excess amount can be recouped from future impairment income benefits paid by the insurance carrier, if any. The employer must file the DWC Form-002, *Employer's Report for Reimbursement of Voluntary Payment*. The DWC Form-002 may be obtained from the TDI website at http://www.tdi.texas.gov/forms/form20employer.html or by calling 1-800-252-7031.

EMPLOYER RESPONSIBILITIES

Reporting Workers' Compensation Insurance Coverage to Employees

Employers must tell their employees that they carry workers' compensation insurance by providing a written notice of coverage to new employees upon hire. The written notice must inform employees of their right to reject workers' compensation coverage and retain their common law right of action. This notice must be in the wording and format prescribed by TDI-DWC's *New Employee Notice*.

Employers must also post a written notice at their place of business telling their employees that they carry workers' compensation insurance. This notice must be in the wording and format prescribed by TDI-DWC's Notice 6, *Notice to Employees Concerning Workers' Compensation in Texas*. The notice must be in English, Spanish, and any other language that is common to the employees and must be posted at conspicuous locations at the employers' place of business.

A written notice must be provided again to each employee and the Notice 6 must be updated when changes in coverage status (obtained, terminated, or canceled) occur. The TDI-DWC's *New Employee Notice* and Notice 6 may be obtained from the TDI website at http://www.tdi.texas.gov/forms/form20employer.html or by calling 1-800-252-7031.

Reporting Injuries and Illnesses

Employers are required to report to its insurance carrier, within 8 days, any:

- work-related injury resulting in the employee's absence from work for more than one day;
- occupational disease of which the employer has knowledge; and
- work-related fatality.

Employers should report these injuries and illnesses using the DWC Form-001, *Employer's First Report of Injury or Illness*. An employer must keep a record of all work-related injuries, illnesses and fatalities for at least 5 years after the date the record was created, or for the period of time required by the Occupational Safety and Health Administration (OSHA), whichever is longer.

The employer must also provide a copy of the completed DWC Form-001 to the injured employee, along with a copy of the *Notice of the Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System*. The DWC Form-001 may be obtained from the TDI website at http://www.tdi.texas.gov/forms/form20employer.html. The employee's notice of rights and responsibilities may be obtained from the TDI website at http://www.oiec.texas.gov/resources/ierightsresp.html. Both forms may also be obtained by calling 1-800-252-7031.

Employer's Wage Statement & Supplemental Report of Injury

An employer must report an injured employee's wages and other fringe benefits (i.e. health premiums, uniform allowance, etc.) to the insurance carrier. The employer is required to send the DWC Form-003, *Employer's Wage Statement,* to the insurance carrier and the injured employee within 30 days of the earliest of: the date the employer is notified that the employee is entitled to income benefits; or the date of employee's death as a result of a compensable injury.

An employer must also report any changes in an injured employee's pay or employment status to the insurance carrier. The employer must send the DWC Form-006, *Supplemental Report of Injury,* to the insurance carrier and the injured employee within:

- 10 days from the end of a pay period in which an employee's pay changes;
- 10 days from the date an employee resigns or is terminated;
- 3 days from the date the employee begins to lose time from work as a result of the injury;
- 3 days from the date an employee returns to work; and
- 3 days from the date an injury causes an employee to miss additional work after returning to work.

Safe Workplace

Employers must take all actions reasonably necessary to ensure a safe workplace and take all steps reasonably necessary to protect the life, health and safety of the employees.

Compliance

Employers that fail to comply with workers' compensation requirements commit an administrative violation and may be subject to administrative penalties. The information provided in this fact sheet and workers' compensation requirements are pursuant to: Texas Labor Code §§406.002, 406.005, 406.007, 406.033, 406.034, 406.096, 408.003, 408.001, 409.011, 409.005, 409.006, 411.032, 411.103 and 413.021; and 28 Texas Administrative Code §§110.101, 120.1, 120.2, 120.3, 120.4, 126.13, 129.7 and 160.3.

If you have any questions regarding reporting requirements or compliance with the law, contact TDI-DWC at 1-800-252-7031. For more information on workers' compensation for employers, visit the TDI website at http://www.tdi.texas.gov/wc/employer/index.html.

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]

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.

CLAIM # _____

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? If No, Specify Language YES ☐ NO ☐
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*
20. How and Why Injury/Illness Occurred*
21. Was employee doing his regular job? YES ☐ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site
Street or P.O. Box County
City State 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: $_____ for ____ Hours or _____ Days
39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form
41. Name of Business
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ( )
City State Zip Code
43. Business Location (If different from mailing address) Number and Street
City State Zip Code
44. Federal Tax Identification Number
45. Primary North American Industry Classification System Code.(6 digit)
46. Specific NAICS Code (6 digit)
47. Texas Comptroller Taxpayer No.
48. Workers' Compensation Insurance Company
49. Policy Number
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 _____

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Name of employer] _____ has workers' compensation insurance coverage from [name of commercial insurance company] _____ in the event of work-related injury or occupational disease. This coverage is effective from [effective date of workers' compensation insurance policy] _____. Any injuries or occupational diseases which occur on or after that date will be handled by [name of commercial insurance company] _____ _____. An employee or a person acting on the employee's behalf, must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

COVERED EMPLOYER

Texas Workers' Compensation Rule 110.101(e)(1) requires employers who are covered by workers' compensation through a commercial insurance company to advise their employees that they do have workers' compensation insurance coverage and to advise their employees of the Texas Department of Insurance, Division of Workers' Compensation's toll free number to obtain additional information about their workers' compensation rights.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

1. Prominently displayed in the employer's personnel office, if any;
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type; and
4. Contain the exact words as prescribed in Rule 110.101(e)(1).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

Do Not Post This Side

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [Name of the employer] _____ _____tiene cobertura de seguros de compensación para trabajadores con [name of the commercial insurance company] _____ para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde [effective date of workers' compensation insurance policy] _____. Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por [name of commercial insurance company]_____ _____. Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO: La División proporciona información gratuita sobre cómo presentar una reclamación de compensación para trabajadores. El personal de la División contestará cualquier pregunta que usted pueda tener sobre la compensación para trabajadores y procesará cualquier solicitud de resolución de disputas relacionada con una reclamación. Usted puede obtener este tipo de asistencia comunicándose con su oficina local de la División o llamando al teléfono 1-800-252-7031. La Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés) también ofrece asistencia gratuita a los empleados lesionados y ellos le explicarán cuáles son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores. Usted puede obtener la asistencia de OIEC comunicándose con un representante de servicio al cliente de OIEC en su oficina local de la División o llamando al 1-866-EZE-OIEC (1-866-393-6432).

LÍNEA DIRECTA PARA REPORTAR VIOLACIONES DE SEGURIDAD: La División cuenta con una línea gratuita telefónica que está en servicio las 24 horas del día para reportar condiciones inseguras en el área de trabajo que podrían violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen en contra de cualquier empleado porque él o ella de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la División al teléfono 1-800-452-9595.

EMPLEADOR CON COBERTURA

El Reglamento 110.101 (e)(1) de Compensación para Trabajadores de Texas requiere que los empleadores que cuentan con una cobertura de compensación para trabajadores mediante una compañía de seguros comercial notifiquen a sus empleados que ellos cuentan con una cobertura de seguro de compensación para trabajadores e informen a sus empleados sobre el número de la línea telefónica gratuita del Departamento de Seguros de Texas, División de Compensación para Trabajadores para obtener información adicional sobre sus derechos de compensación para trabajadores.

Avisos en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista y:

1. Mostrarse en un lugar prominente de la oficina de personal del empleador, si es que la hay;
2. Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;
3. El título debe ser impreso en tamaño 26, en letra negrita de punto, el tema debe ser impreso en tamaño 18, en letra negrita de punto, y el texto, por lo menos en tamaño 16 en letra negrita de punto normal; y
4. Contener las palabras exactas según lo señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra al reverso de esta página cumple con los requisitos que se han señalado en la parte de arriba. El negarse a mostrar o proporcionar esta información, según lo requerido en el reglamento es una falta a la ley y a los reglamentos de la División. El infractor podría estar sujeto a sanciones administrativas.

NO MOSTRAR ESTE LADO

OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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.**

OFFICE OF INJURED EMPLOYEE COUNSEL
NORMAN DARWIN, PUBLIC COUNSEL

Aviso sobre los Derechos y Responsabilidades para los Empleados Lesionados en el Sistema de Compensación para Trabajadores de Texas

En Texas, usted como empleado lesionado tiene derecho a recibir ayuda gratuita por parte de la Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel -OIEC, por su nombre y siglas en inglés). Esta ayuda se ofrece en las oficinas locales en todo el estado. Las oficinas locales también proporcionan otros servicios del sistema de compensación para trabajadores por parte del Departamento de Seguros de Texas (Texas Department of Insurance -TDI, por su nombre y siglas en inglés). TDI, es la agencia estatal que regula y administra el sistema de compensación para trabajadores mediante la División de Compensación para Trabajadores (Division of Workers' Compensation –DWC, por su nombre y siglas en inglés).

Muchos de los servicios que son proporcionados por parte de OIEC y de DWC pueden ser llevados a cabo por teléfono. Usted puede comunicarse con OIEC llamando al teléfono gratuito 1-866-EZE-OIEC (1-866-393-6432). Visite el sitio Web de OIEC en www.oiec.texas.gov, para obtener información adicional, incluyendo la ubicación de las oficinas. Usted puede comunicarse con DWC llamando al teléfono gratuito 1-800-252-7031. La información de DWC se encuentra disponible en la página de Internet: www.tdi.texas.gov.

Sus Derechos Dentro del Sistema de Compensación para Trabajadores de Texas:

1. **Usted tiene derecho a contratar a un abogado para asistirle con su reclamación de compensación para trabajadores.**
   Para obtener asistencia para encontrar a un abogado, llame al servicio de recomendación de abogados de la Barra de Abogados del Estado de Texas (State Bar of Texas, por su nombre en inglés) al 1-877-983-9227 o visite www.texasbar.com. La información sobre la recomendación de abogados también puede encontrarse en la página de Internet de OIEC en www.oiec.texas.gov.

2. **Usted tiene derecho a recibir asistencia por parte de OIEC si no cuenta con un abogado.**
   Los Representantes de Servicio al Cliente de OIEC, así como los Ombudsman están disponibles para responder a sus preguntas y proporcionarle asistencia con su reclamación de compensación para trabajadores ya sea llamando a OIEC o visitando una de las oficinas de OIEC. **Usted debe firmar una autorización por escrito antes que un empleado de OIEC pueda tener acceso a la información sobre su reclamación.** Llame o visite una oficina de OIEC para completar la autorización por escrito. Los Representantes de Servicio al Cliente de OIEC y los Ombudsman han sido entrenados en el campo de compensación para trabajadores y pueden ayudarle a programar un procedimiento de resolución de disputas, relacionado con su reclamación de compensación para trabajadores. Un ombudsman también puede asistirle en una Conferencia para Revisión de Beneficios (Benefit Review Conference –BRC, por su nombre y siglas en inglés), en una Audiencia para Disputar Beneficios (Contested Case Hearing –CCH, por su nombre y siglas en inglés), y en una apelación. Sin embargo, un Ombudsman no puede tomar decisiones por usted, ni dar opiniones por usted o proporcionar asesoramiento legal.

3. **Con ciertas excepciones, usted tiene derecho a recibir beneficios médicos y beneficios de ingresos sin importar quién tuvo la culpa de su lesión. Sus beneficiarios podían tener derecho a recibir beneficios por causa de muerte y beneficios de gastos para el entierro.**
   La información sobre las excepciones puede encontrarse en www.tdi.texas.gov o consultando al personal de OIEC.

4. **Usted puede tener derecho a recibir atención médica para atender su lesión o enfermedad que sucedió en el área de trabajo, durante todo el tiempo que sea médicamente necesario y relacionado con la lesión que sucedió en el área de trabajo.**
   Usted puede tener derecho a recibir un reembolso por los gastos incurridos después de viajar para asistir a una cita médica o a un examen médico requerido (required medical examination, por su nombre en inglés), si el viaje cumple con las condiciones de calificación.

5. **Usted puede tener derecho a recibir beneficios de ingresos por su lesión relacionada con el trabajo.**
   Existen varios tipos de beneficios de ingresos, así como requisitos de elegibilidad. La información sobre los tipos de beneficios de ingresos que pueden estar disponibles, y los requisitos de elegibilidad pueden ser encontrados en www.tdi.texas.gov o consultando al personal de OIEC.

6. **Usted puede tener derecho a una resolución de disputas con respecto a sus beneficios de ingresos y beneficios médicos.**
   Usted puede solicitar una Resolución de Disputas Médicas (Medical Dispute Resolution, por su nombre en inglés) si está en desacuerdo con la aseguradora sobre los beneficios médicos. Usted puede solicitar una Resolución de Disputas por Indemnización (Ingresos) (Indemnity (Income) Dispute Resolution, por su nombre en inglés), si está en desacuerdo con la aseguradora sobre los beneficios de ingresos. La ley establece que sus procedimientos de resolución de disputas sean llevados a cabo dentro de 75 millas del domicilio suyo.

7. **Usted tiene derecho a escoger a su médico de tratamiento.**
   Si usted pertenece a una red de servicios médicos de compensación para trabajadores (Workers' Compensation Health Care Network), (red), debe escoger a su médico de la lista de médicos de tratamiento de la red. Usted puede cambiar a su médico de tratamiento una sola vez sin la necesidad de obtener la aprobación de la red. Si no pertenece a una red, usted puede inicialmente escoger a cualquier médico que esté dispuesto a atender su lesión de compensación para trabajadores; sin embargo, si usted no pertenece a una red, el cambio de su médico de tratamiento debe ser pre-aprobado por DWC. Si es empleado de una subdivisión política, tal como la ciudad, el condado, o el distrito escolar, usted deberá seguir los reglamentos de dicha subdivisión política para escoger a un médico de tratamiento. Es importante seguir todos los reglamentos en el sistema de compensación para trabajadores. **Si usted no sigue estos reglamentos, podría ser considerado responsable por el pago de las facturas médicas.** El personal de OIEC puede ayudarle a entender estos reglamentos.

8. **Usted tiene derecho a que la información sobre su reclamación de compensación para trabajadores se mantenga confidencial.**
   En la mayoría de los casos, el contenido del expediente de su reclamación no puede ser obtenido por otras personas. Algunos participantes tienen derecho a conocer el contenido del expediente de su reclamación, tal como su empleador o la aseguradora de su empleador. También, un empleador que esté considerando contratarle a usted puede obtener información limitada por parte de DWC sobre su reclamación.

Sus Responsabilidades Dentro del Sistema de Compensación para Trabajadores de Texas:

1. **Usted tiene la responsabilidad de informar a su empleador si se ha lesionado en el trabajo mientras desempeñaba sus deberes de trabajo. Usted debe informar a su empleador dentro de 30 días a partir de la fecha en que sucedió su lesión o del día en que usted se dio cuenta que su lesión o enfermedad podría estar relacionada con su trabajo.**

2. **Usted tiene la responsabilidad de saber si pertenece a una Red de Servicios Médicos de Compensación para Trabajadores (red) (Workers' Compensation Health Care Network -network).**
   Si no sabe si pertenece a una red de servicios médicos, pregúntele al empleador para el cual usted trabajaba al momento en que ocurrió su lesión. Si pertenece a una red, es su responsabilidad seguir los reglamentos de dicha red. Si usted encuentra algo que no entiende, pregunte a su empleador o llame a OIEC. Si desea presentar una queja sobre una red, llame a la Línea de Ayuda al Consumidor de TDI (TDI's Consumer Help Line, por su nombre en inglés) al 1-800-252-3439 o presente su queja en línea en www.tdi.texas.gov/consumer/complfrm.html#wc.

3. **Si usted trabajó para una subdivisión política (p. ej. la ciudad, el condado o el distrito escolar) al momento en que sucedió su lesión, es su responsabilidad averiguar cómo recibir tratamiento médico.**
   Su empleador debe poder proporcionar la información que usted necesita para determinar cuáles son los proveedores de servicios médicos que pueden atender su lesión relacionada con el trabajo.

4. **Usted tiene la responsabilidad de informar a su médico cómo es que usted se lesionó y determinar si la lesión está relacionada con el trabajo.**

5. **Usted tiene la responsabilidad de completar y enviar a DWC el Formulario DWC-041, Reclamo del Empleado para Compensación por una Lesión Relacionada con el Trabajo o Enfermedad Ocupacional.**
   Usted cuenta con un año para enviar el formulario después de haberse lesionado o después de haberse enterado que su enfermedad podría estar relacionada con su trabajo. Complete y envíe el Formulario DWC-041 aun si ya está recibiendo beneficios. Usted puede perder su derecho a recibir beneficios si no envía a tiempo el formulario completo a DWC. Para obtener una copia del Formulario DWC-041 comuníquese con DWC o con OIEC.

6. **Usted tiene la responsabilidad de proporcionar su dirección actual, número de teléfono e información sobre su empleador a DWC y a la aseguradora. Usted puede comunicarse con DWC al 1-800-252-7031.**

7. **Usted tiene la responsabilidad de informarle a DWC y a la aseguradora cada vez que haya un cambio en el estado de su empleo o su salario.**
   (Algunos ejemplos de cambios incluyen: si deja de trabajar a causa de su lesión; si usted regresa a trabajar; o si recibe una oferta de trabajo).

8. **Los beneficiarios que son elegibles o las personas que buscan obtener beneficios por causa de muerte o beneficios de gastos para el entierro, tienen la responsabilidad de completar y enviar a DWC el Formulario DWC-042, Reclamación del Beneficiario para Obtener Beneficios por Causa de Muerte dentro de un año, a partir de la fecha en que el empleado falleció.**

9. **Usted tiene prohibido hacer reclamaciones o demandas injustificadas o fraudulentas.**

Texas Department Of Insurance

Division of Workers' Compensation
Records Processing
7551 Metro Center Dr. Ste.100 • MS-94
Austin, TX 78744-1609
(800) 252-7031 (512) 804-4378 fax www.tdi.texas.gov

DWC Claim#
Carrier Claim#

← Send the completed form to this address.

Employee's Claim for Compensation for a Work-Related Injury or Occupational Disease (DWC Form-041)

Claim for workers' compensation must be filed by the injured employee or by a person acting on the injured employee's behalf **within one year** of the date of injury or within one year from the date the injured employee knew or should have known the injury or disease may be work-related.

I. INJURED EMPLOYEE INFORMATION

Name (First, Middle, Last)	**Social Security Number**	**Date of birth** (mm / dd / yyyy)
Address (street, city/town, state, zip code, county, country)		
Phone Number	**E-Mail address**	**Sex** ☐Male ☐Female
Race / Ethnicity ☐White, not of Hispanic Origin ☐ Black, not of Hispanic Origin ☐Hispanic ☐ Asian or Pacific Islander		
Do you speak English? ☐ Yes ☐ No If no, specify language		
Marital status ☐ Married ☐ Widowed ☐Separated ☐Single ☐Divorced		
Do you have an attorney or other representation? ☐Yes ☐No **If yes, name of representative**		
Have you returned to work? ☐Yes ☐No	**If returned to work, date returned** (mm/dd/yyyy)	**Work status** ☐Regular ☐Restricted
Occupation at time of injury		**Date of hire** (mm / dd / yyyy)
Hired or recruited in Texas ☐ Yes ☐ No	**Pre-tax wages** (at the time of injury) $	☐hourly ☐ weekly ☐monthly

II. INJURY INFORMATION

I am reporting an ☐ injury **or** ☐ occupational disease	**Date of injury** (mm / dd / yyyy)	**Time of injury**
First work day missed (mm / dd / yyyy)	**Date injury was reported to the employer** (mm / dd / yyyy)	
Where did the injury occur? County	**State**	**Country**
If accident occurred outside of Texas, on what date did you leave Texas? (mm/dd/yyyy)		
Witness(es) to the injury (list by name)		
Describe cause of injury or occupational disease, including how it is work related		
Body part(s) affected by the injury		
If injury is the result of an occupational disease: **1. On what date was the employee last exposed to the cause of the occupational disease?** (mm / dd / yyyy) **2. When did you first know occupational disease was work related?** (mm / dd / yyyy)		

III. EMPLOYER INFORMATION (at the time of injury)

Employer name	**Employer address** (street, city/town, state, zip code, county, country)
Employer phone number	**Supervisor name**

IV. DOCTOR INFORMATION

Name of treating doctor	**Phone number**
Address (street, city/town, state, zip code)	
Name of workers' compensation health care network, if any	

Signature of injured employee or person filling out this form on behalf of injured employee **Date**

Printed name of injured employee or person filling out form on behalf of injured employee

Information about Employee's Claim for Compensation for a Work-Related Injury or Occupational Disease (DWC Form-041)

A claim for Workers' Compensation benefits must be filed with the Division of Workers' Compensation (Division) by the injured employee (you), or by a person acting on the injured employee's (your) behalf within *one year* of the injury or within *one year* from the date you knew or should have known the injury or disease may be work related; UNLESS good cause exists for the failure to timely file a claim, or the employer or the employer's insurance carrier does not contest the claim.

Upon receipt of your completed DWC Form-041, or other notice of your injury, the Division will create a claim and establish a DWC claim number for you, and the Division will mail information regarding workers' compensation in Texas to you. The Division will also notify your employer and the employer's workers' compensation insurance carrier.

SPECIAL INSTRUCTIONS AND INFORMATION FOR COMPLETING THE DWC Form-041

General Instructions

- **Complete all boxes in the DWC Form-041**.
- If you have questions about completing this form, please call your local Division Field Office at 1-800-252-7031.

Injured Employee Information

- Work Status information
  - If you have returned to your regular job and you are performing the same duties as you were before your injury, check the "Regular" box.
  - If you have been released to work with restrictions by a doctor, check "Restricted."

Injury Information

- An *injury* is damage to your body that was caused by a single incident, accident, or event.
- An *occupational disease* is an illness or injury related to or caused by the work you do, and may include injuries to your body that are the result of repetitive activities you performed on the job over a period of time.

Employer Information

- Provide information about your employer at the time you were injured.

Doctor Information

- If you already have a workers' compensation treating doctor, provide the name and address of the doctor.
- If you are covered under a workers' compensation healthcare network, provide the name of the network.

Contacting Texas Department of Insurance, Division of Workers' Compensation

If you have questions about filling out this form or workers' compensation in Texas, please call your local Division Field Office at 1-800-252-7031.

NOTE: With few exceptions, you are entitled, on request, to be informed about the information that the Division collects or maintains about you and your workers' compensation claim. Under §552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review the information. Under §559.004 of the Texas Government Code you are entitled to have the Division correct information the Division creates about you or your workers' compensation claim that is incorrect. For more information, call the Division's Open Records section at 512-804-4437.

Texas Department Of Insurance

Division of Workers' Compensation
Records Processing
7551 Metro Center Dr. Ste.100 • MS-94
Austin, TX 78744-1609
(800) 252-7031 (512) 804-4378 fax http://www.tdi.texas.gov

DWC Claim#
Carrier Claim#

← Envíe el formulario completo a esta dirección.

Reclamo del Empleado para Compensación por una Lesión Relacionada con el Trabajo o Enfermedad Ocupacional (Formulario DWC-041)

El reclamo de compensación para trabajadores debe ser sometido por el empleado lesionado o por la persona actuando en nombre del empleado lesionado **dentro de un año** a partir de la fecha en que sucedió la lesión o dentro de un año a partir de la fecha en que e empleado lesionado supo o debió haber sabido que la enfermedad estaba relacionada con el trabajo.

I. INFORMACIÓN SOBRE EL EMPLEADO LESIONADO

Nombre (Primer Nombre, Segundo Nombre, Apellido)	**Número de Seguro Social**	**Fecha de Nacimiento** (mes / día / año)
Dirección (calle, ciudad/pueblo, estado, código postal, condado, país)		
Número de Teléfono	**Dirección de Correo Electrónico**	**Sexo** ☐Hombre ☐Mujer
Raza / Origen Étnico ☐Blanco, no de origen Hispano ☐Negro, no de origen Hispano ☐Hispano ☐Asiático o Habitante de las Islas del Pacífico		
¿Habla usted Inglés? ☐ Si ☐ No Si la respuesta es no, especifique el idioma		
Estado Civil ☐ Casado(a) ☐ Viudo(a) ☐ Separado(a) ☐ Soltero(a) ☐ Divorciado(a)		
¿Cuenta usted con un abogado u otro tipo de representación? ☐Si ☐No **Si su respuesta es si, proporcione el nombre de su representante**		
¿Ha regresado usted a trabajar? ☐Si ☐No	**Si usted ya regresó a trabajar, dé la fecha en que regresó a su trabajo** (mes/día/año)	**Estado de Trabajo** ☐Regular ☐ Limitado
Su ocupación al momento de la lesión		**Fecha en que fue contratado** (mes/ día/ año)
¿Fue usted contratado en Texas? ☐ Si ☐ No	**Salarios antes de los impuestos** $	☐ Por hora ☐ Semanal ☐ Mensual

II. INFORMACIÓN SOBRE LA LESIÓN

Estoy reportando una ☐ lesión o ☐ una enfermedad ocupacional	**Fecha de la lesión** (mes/día/año)
Hora en que sucedió la lesión	**Primer día que no trabajó por causa de la lesión** (mes/día/año)
Fecha en que la lesión fue reportada al empleador (mes/día/año)	
¿Dónde ocurrió la lesión? **Condado** **Estado** **País**	
Si el accidente ocurrió fuera de Texas, ¿en qué fecha salió usted de Texas? (mes/día/año)	
Testigo(s) de la lesión (enliste los nombres)	
Describa la causa de la lesión o enfermedad ocupacional, incluyendo como es que está relacionada con el trabajo.	
Parte(s) del cuerpo afectada(s) por la lesión	
Si la lesión es el resultado de una enfermedad ocupacional: **1. ¿En qué fecha fue la última vez que el empleado estuvo expuesto a la causa de la enfermedad ocupacional?** (mes / día / año) **2. ¿Cuándo fue que usted se dio cuenta que la enfermedad ocupacional estaba relacionada con su trabajo?** (mes / día / año)	

III. INFORMACIÓN SOBRE EL EMPLEADOR (al momento de la lesión)

Nombre del Empleador	**Dirección del Empleador** (calle, ciudad/pueblo, estado, código postal, condado, país)
Número de Teléfono del Empleador	**Nombre del Supervisor**

IV. INFORMACIÓN SOBRE EL MÉDICO

Nombre del Médico Tratante	**Número de Teléfono**
Dirección (calle, ciudad/pueblo, estado, código postal)	
Nombre de la Red de Servicios Médicos de Compensación para Trabajadores, si es que la hay	

Firma del empleado lesionado o de la persona que está completando este formulario en nombre del empleado lesionado **Fecha**

Nombre en letra de molde del empleado lesionado o de la persona que está completando este formulario

Información sobre el Reclamo del Empleado para Compensación por una Lesión Relacionada con el Trabajo o Enfermedad Ocupacional (Formulario DWC-041)

Un reclamo para recibir beneficios de compensación para trabajadores debe ser sometido con la División de Compensación para Trabajadores (División) por el empleado lesionado (usted), o por la persona que está actuando en nombre (suyo) del empleado lesionado dentro de *un año* a partir de la fecha en que usted supo o debió haber sabido que la lesión o enfermedad podía estar relacionada con el trabajo; AL MENOS que exista una buena causa para no poder someter el reclamo a tiempo, o si el empleador o la compañía de seguros no disputan el reclamo.

Una vez que se haya recibido su formulario DWC041, u otro aviso sobre su lesión, la División creará un reclamo y establecerá un número de reclamo para usted, y la División le enviará a usted por correo información referente a la compensación para trabajadores en Texas. La División también notificará a su empleador, y a su compañía de seguros de compensación para trabajadores.

INSTRUCCIONES ESPECIALES E INFORMACIÓN PARA COMPLETAR EL FORMULARIO DWC-041

Instrucciones en General

- **Complete todas las casillas en el formulario DWC-041**
- Si usted tiene alguna pregunta sobre como completar este formulario, favor llame a la oficina local de la División al teléfono 1-800-252-7031.

Información Sobre el Empleado Lesionado

- Información sobre el Estado de Trabajo
  - Si usted ha regresado a su trabajo regular y está desempeñando los mismos deberes que tenía antes de que sucediera su lesión, marque la casilla que indica “Regular”.
  - Si usted ha sido dado de alta por un médico para regresar a trabajar con restricciones, marque la casilla que indica “Limitado”.

Información Sobre la Lesión

- Una *lesión* significa un daño a su cuerpo que fue causado por un accidente, o evento.
- Una *enfermedad ocupacional* significa una enfermedad o lesión relacionada con o causada por el trabajo que usted desempeña, y puede incluir lesiones a su cuerpo que son el resultado de actividades repetitivas que usted desempeña en el trabajo en un periodo de tiempo.

Información Sobre el Empleador

Proporcione información sobre su empleador al momento en que usted se lesionó.

Información Sobre el Médico

- Si usted ya cuenta con un médico tratante de compensación para trabajadores, proporcione el nombre y dirección del médico.
- Si usted está cubierto bajo una red de servicios médicos de compensación para trabajadores, proporcione el nombre de la red.

Como Comunicarse con el Departamento de Seguros de Texas, División de Compensación para Trabajadores

Si usted tiene preguntas sobre como llenar este formulario o tiene preguntas sobre la compensación para trabajadores en Texas, por favor llame a la oficina local de la División al teléfono 1-800-252-7031.

NOTA: Con pocas excepciones, usted tiene derecho, cuando lo solicita, de ser informado sobre la información que la División reúne o mantiene sobre usted y sobre su reclamo de compensación para trabajadores. Bajo la Sección §552.021 y 552.023 del Código Gubernamental de Texas, usted tiene derecho a recibir y revisar esta información. Bajo la Sección §559.004 del Código Gubernamental de Texas, usted tiene derecho para que la División corrija la información que ha sido creada sobre usted y su reclamo y que está incorrecta. Para mayor información, llame a nuestra Sección de Archivos y Documentos Públicos “Open Records” al teléfono 512-804-4437.

Workers' Compensation Temporary Prescription ID Card

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 1-866-590-5882.

Atencion Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 1-866-590-5882.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at 1-866-590-5882.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control A4

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

Express Scripts

ID #: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____
MM/DD/YYYY

Group #: GJC6200

Employee Date of Birth: _____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____ First _____ M _____ Last

_____ Street Address or PO Box

_____ City _____ State _____ ZIP

Employer Name

_____

sedgwick

EXPRESS SCRIPTS®

Participating Retail Network Pharmacies

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource
Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale
Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy
Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School
Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network
Pharmaceuticals
Northeast
Pharmacy Services
Osco
P & C Food
Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology
Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United
Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

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