

COUNTY MUTUAL CARE LINESM
POWERED BY ALARIS

CARE LINE INSTRUCTIONS
1-855-650-6580

MANDATORY FOR USE ON WORKER'S COMPENSATION INJURIES

The Care Line® must be utilized on all work-related injuries **REQUIRING TREATMENT** for the following:

- » Back
- » Neck
- » Knees
- » Shoulders
- » Head

Aegis has since confirmed to call the Care Line for any injury to any body part regardless if you are seeking treatment or not. Aegis has indicated it is the responsibility of the employee and/or the supervisor to call the Care Line. The Care Line is a best practice process of Aegis whereby you will be in contact with a nurse. June 9, 2017

This includes all muscle strains, sprains, fractures, contusions, and cuts to the body part above.

Please **DO NOT** call the Care Line® if you do not intend to seek treatment for your injury. You will need to report the incident to your supervisor or the individual designated to receive worker's compensation claims to note the event.

All serious injuries should be treated immediately and reported as soon as possible. All other claims meeting the above criteria should utilize the Care Line® Nurse to assess the injuries and provide helpful instructions.

IN CASE OF EMERGENCY, DIAL 911

FIRST NOTIFICATION OF INJURY FORM

TO BE COMPLETED BY THE SUPERVISOR

SUPERVISOR'S REPORT

INJURED PERSON: _____ DATE: _____ CHECK ONE EMPLOYEE VISITOR VOLUNTEER

NAME AND POSITION OF PERSON PREPARING REPORT: _____

DEPARTMENT: _____ SUPERVISOR'S PHONE NUMBER: _____

DATE OF INJURY: _____ TIME OF INJURY: _____ A.M. P.M. LEFT WORK? (CLICK) **YES** **NO**

ADDRESS OF ACCIDENT: _____

WHAT WAS THE EMPLOYEE DOING WHEN INJURED? BE SPECIFIC. PLEASE NAME ANY EQUIPMENT USED.

HOW DID THE ACCIDENT OCCUR?

HOW LONG HAS THE EMPLOYEE BEEN ON THE JOB? _____ DAYS _____ MONTHS _____ YEARS

WHAT SAFETY EQUIPMENT IS REQUIRED ON THE JOB FOR THE WORK BEING PERFORMED?

WAS THE EMPLOYEE USING ALL REQUIRED SAFETY EQUIPMENT? (CLICK) **YES** **NO**

IF NO, WHICH SPECIFIC PERSON PROTECTIVE EQUIPMENT WAS NOT USED & WHY?

DOES AN UNSAFE CONDITION EXIST THAT CONTRIBUTED TO THE CAUSE? (CLICK) **YES** **NO**

IF YES, WHAT IS THE CONDITION?

HOW COULD THIS ACCIDENT BEEN PREVENTED?

CORRECTIVE ACTION TAKEN BY SUPERVISOR? (CLICK) **YES** **NO** DATE: _____

REINSTRUCTION OF PERSON(S) INVOLVED?	YES	NO
EQUIPMENT REPAIR/REPLACEMENT?	YES	NO
IMPROVED PERSONAL PROTECTION EQUIPMENT?	YES	NO
REDUCED CONGESTION?	YES	NO
IMPROVED DESIGN/CONSTRUCTION?	YES	NO
DISCIPLINE OF PERSON(S) INVOLVED?	YES	NO

OTHER: _____

IN DETAIL, PLEASE EXPLAIN ACTION TAKEN TO PREVENT RECURRENCE:

EMPLOYEE INFORMATION

NAME: [] SSN: [] GENDER [] M [] F HOME PHONE: [] ADDRESS: [] CITY: [] STATE: [] ZIP: [] BIRTHDATE: []

EMPLOYMENT HISTORY

OCCUPATION: [] DEPARTMENT: [] DATE HIRED: []

ACCIDENT INFORMATION

DATE OF INJURY: [] TIME OF INJURY: [] DATE REPORTED: []

NAME OF INDIVIDUAL THE INJURY WAS REPORTED TO: []

IN YOUR OWN WORDS, EXPLAIN IN DETAIL WHAT YOU WERE DOING IMMEDIATELY BEFORE THE ACCIDENT AND HOW THE ACCIDENT OCCURRED:

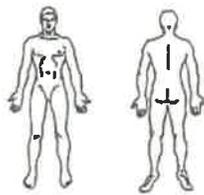
[]

WITNESS?: [] DID/WILL YOU SEEK MEDICAL TREATMENT? (CLICK) YES NO

IF YES, PLEASE PROVIDE PHYSICIAN:

CLINIC: [] PHYSICIAN: [] ADDRESS: [] PHONE: []

INDICATE ON THE DIAGRAM THE LOCATION OF INJURY



DESCRIBE SYMPTOMS: []

I HEREBY CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

DATE: [] SIGNATURE: []

EMPLOYER SECTION:

PLEASE CHECK ONE:

EMPLOYEE HAS NOT MISSED TIME FROM WORK [] EMPLOYEE IS OFF WORK []

IF EMPLOYEE IS OFF WORK, PLEASE INDICATE REASON

AUTHORIZED OFF WORK [] WORK RESTRICTIONS []

PLEASE SUBMIT REPORT TO:

COUNTY [] NAME [] PHONE [] FAX []

PLEASE BE SURE TO ATTACH A COPY OF THE PHYSICIAN'S RETURN TO WORK REPORT IF AVAILABLE

FAX REPORT TO AEGIS CORPORATION AT 262-252-6579 WITHIN 24 HOURS

SUPERVISOR OR HR REPRESENTATIVE: [] PHONE: []

Sample - doc slip needed after each appt.

WORKER'S COMPENSATION

ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD

EMPLOYER NAME:

CLAIM NUMBER:

PATIENT NAME:

DATE OF INJURY:

TO BE COMPLETED BY ATTENDING PHYSICIAN - PLEASE CHECK

DIAGNOSIS/CONDITION (BRIEF EXPLANATION)

I SAW AND TREATED THIS PATIENT ON (DATE) AND BASED ON THE ABOVE DESCRIPTION OF THE PATIENT'S CURRENT MEDICAL PROBLEM:

1. RECOMMEND HIS/HER RETURN TO WORK WITH NO LIMITATIONS ON: (DATE)

2. HE/SHE MAY RETURN TO WORK ON: (DATE) CAPABLE OF PERFORMING THE DEGREE OF WORK CHECKED BELOW WITH THE FOLLOWING LIMITATIONS:

- SEDENTARY WORK. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as docket, ledgers, and small tools.
LIGHT WORK. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds.
LIGHT MEDIUM WORK. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.
MEDIUM WORK. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.
MEDIUM HEAVY WORK. Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.
HEAVY WORK. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

1. In an 8-hour work day, the patient may:

- a. Stand/Walk NONE 1-4 Hours 4-6 Hours 6-8 Hours
b. Sit 1-3 Hours 3-5 Hours 5-8 Hours
c. Drive 1-3 Hours 3-5 Hours 5-8 Hours

2. Patient may use hand(s) for repetitive:

- Single Grasping
Pushing or Pulling
Fine Manipulation

3. Patient may use foot/feet for repetitive movement as in operating foot controls:

- YES NO

4. Patient is able to:

Table with columns: FREQUENTLY, OCCASIONALLY, NOT AT ALL. Rows: Bend, Squat, Climb, Twist, Reach.

OTHER INSTRUCTIONS AND/OR LIMITATIONS INCLUDING PRESCRIBED MEDICATIONS:

THESE RESTRICTIONS ARE IN EFFECT UNTIL: (DATE) OR UNTIL THE PATIENT IS RE-EVALUATED ON: (DATE)

3. HE/SHE IS TOTALLY INCAPACITATED AT THIS TIME. PATIENT WILL BE RE-EVALUATED ON: (DATE)

NAME OF PROVIDER:

DATE:

PHYSICIAN:

PHYSICIAN'S SIGNATURE:



AEGIS CORPORATION

18550 WEST CAPITOL DRIVE, BROOKFIELD, WI 53045

TOLL FREE: 1-800-236-6885 LOCAL: 262-781-7020

FAX: 262-781-7743

EMAIL: jondrejka@aegis-wi.com

WORKER'S COMPENSATION
RELEASE OF MEDICAL RECORDS AUTHORIZATION

(optional at this time)

By law, all health care providers must provide any employee, employer, workers compensation insurer or their representative any information reasonably related to any alleged work injury. However, determining the relationship of prior medical records to a work injury can be difficult and time consuming. Therefore, to assist in the timely investigation of your claim, this document authorizes the health care provider to release medical information without attempting to determine the extent of its relationship to your alleged work injury:

NAME OF PROVIDER:			
PROVIDER ADDRESS:			
PHYSICIAN:		EMPLOYER NAME:	
PATIENT NAME:		PATIENT D.O.B.:	
PATIENT SSN:		WC CLAIM NO.:	

The patient named above hereby authorized the health care provider named above to disclose all records checked below in its possession relating to the patient's health, treatment, and evaluation to:

NAME & ADDRESS OF PARTY AUTHORIZED TO RECEIVE PROTECTED INFORMATION:	Aegis Corporation 18550 West Capitol Drive Brookfield, WI 53045
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or its designated representatives, and to furnish to them a legible, certified duplicate of all records, writings, reports, test results and x-rays in its possession containing such information. This authorization includes all records, reports, correspondence, or other materials in the possession of the health care provider authorized, even if those materials were not generated by the health care provider, and the redisclosure of such materials is hereby authorized. This release is for use in the investigation, preparation, evaluation, and/or hearing of the worker's compensation claim described above.

PHYSICAL ONLY:

Release all records, correspondence, and any other information from whatever source regarding the patient's physical health, treatment and evaluation including, but not limited to, any made or provided by any physician, nurse, chiropractor, osteopath, dentist, physical therapist, hospital, or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited to Wis. Stat. §§ 51.30, 146.025, 146.81, and 146.82, 42 C.F.R., Chap. 1, subpart C., § 2.31 and 45 C.F.R. § 164.508.

In signing this consent form, I acknowledge that I understand that:

- I am authorizing release of the records and information listed above.
- I am waiving any privilege that may otherwise prevent disclosure of the records and information listed above.
- I understand that the health care provider named above, whom I am authorizing to disclose my protected health information, may not condition my treatment, payment, enrollment or eligibility for benefits (if applicable) on whether I sign this authorization, except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.
- I may revoke this authorization at any time by a written request to the party authorized above to receive information, except that the party authorized above to receive such information may rely upon any personal health information received before the revocation of this authorization. Any by notifying the disclosing medical records/health information department in writing.
- I may obtain a copy of the disclosed medical records and information, upon written request to the party authorized above to receive information, at no charge to me.
- My personal health information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal law. My personal health information may be released to any of the following: the employer; the worker's compensation insurer; the Department of Workforce Development; other parties to this matter or their attorneys; the Labor and Industry Review Commission; any court on any action of proceeding relating to this matter; experts retained or consulted by any party; and any of their agents, employees, or representatives. I specifically authorize and consent to any such disclosure and redisclosure.
- I am entitled to a copy of this consent form after I sign it.

This consent is subject to revocation at any time. If not revoked, this consent is effective for two (2) years from date signed. This authorization expressly waives any requirement that it must be used within a certain number of days after the date of signing, or that it must be dated within any time period before the date it is used. This authorization shall also extend to records of future treatment, after the date of signing of this authorization, as long as such treatment occurs while this authorization is still in effect. A photocopy shall be valid as the original.

PATIENT SIGNATURE
(OR PERSON AUTHORIZED TO SIGN FOR PATIENT):

DATE:



Employer Contact Information

Kewaunee County
810 Lincoln Street
Kewaunee, WI 54216
Employer contact: Peggy Jeanquart, County Administrator's Office
jeanquart.peggy@kewauneeco.org, phone: 920-388-7164

Workers Compensation Carrier Contact Information

Aegis Corporation
18550 West Capitol Drive
Brookfield, WI 53045-1925
general phone: 800-236-6885, general fax: 262-783-6091
Workers Comp contact: Jean Ondrejka phone: 877-746-0355
jondrejka@aegis-wi.com

Provider should send medical bills/claims to:

**Aegis Corporation
18550 West Capitol Drive
Brookfield, WI 53045-1925**

* If for some reason the employee receives a bill from the provider, that is most likely because the provider was not given the address/ information for billing to Aegis. In this case, you should notify your provider of the above workers compensation contact information so the bill can be submitted to the appropriate address. This will also make sure that going forward - any future provider visits/bills are forwarded to Aegis and not to your home.