Broome County Office of Risk Management
Broome County **Office** Building . 60 Hawley Street
P.O. Box 1766, Binghamton, NY 13902 www.gobroomecounty.com
Main Office: Phone (607)778-2402 Fax: (607)778-2918

Workers Compensation Packet and Instructions Effective April 1, 2018

PINK PACKET

1. **Instructions** – to be read by employee (claimant) and supervisor and retained by employee.

2. **C-3 – New York State Employee claim form** to be completed by claimant.

3. **WC Form 1 Claimant's Statement** – to be completed and signed by claimant.

4. **WC Form 2 Supervisor's Statement** – to be completed and signed by Supervisor and provided to the Department Head for signature.

5. **WC Form 3 Witness Statement** – to be completed by any and all witnesses of the reported accident/incident. Each witness must complete a separate statement.

6. **WC Form 4 Authorization to Release Records** – to be completed and signed by the claimant.

7. **WC Form 5 Notice to Claimant** – to be signed by the claimant.

8. **WC Form 6 Treating Physicians Report** – to be retained by the claimant and taken to each physician visit.

Forms C-3, WC Form 1, WC Form 2, WC Form 3 (all copies), WC Form 4, and WC Form 5 must be submitted to Risk & Insurance

For quicker notifications, the packet can be faxed to (607) 778-2918 or emailed to bcworkerscomp@co.broome.ny.us, but all originals must be forwarded to Risk & Insurance via interoffice mail or through standard mail

Broome County Office of Risk Management
Broome County Office Building . 60 Hawley Street
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Procedure for Reporting Workers' Compensation Injury

Employee Responsibilities:

1. Notify the supervisor of the accident/incident immediately.
2. The workers compensation packet must be completed in full (Incomplete packets may be returned), signed and returned to Risk & Insurance within 5 days. Please call 778-6474 for questions regarding claims.
3. **Retain this Instruction form, WC Form 6- Physicians report and a copy of the packet**, for your records. The Treating Physicians report must be taken to each doctors' visit.
4. **Billing Information (You are responsible for giving this information to your Physician and Providers), and Prescription Information Noted below:**

TRIADGROUP
400 Jordan Road Troy, NY 12180
Tel: 800-337-7419
www.triadgate.com
PLEASE PROVIDE INFORMATION TO YOUR PHYSICIAN

BE SURE TO TELL YOUR PHARMACIST
Rx prescriptions processed through
AWPRx
BIN: 610237
PCN: AWPRX
GROUP: TRD999
Pharmacist Assistance (888)700-0922
Claimant Customer Service (888)700-0185
Radiological testing, xray, MRI, CT scan, scheduled through **One Call Medical**
(800) 872-2875
Call them to schedule an appointment at a facility near you

5. **Failure to schedule through our network for diagnostic testing, will result in refusal of payment. All requests for treatment should be faxed to (607) 778-2918, Attention: Workers' Compensation.**

Supervisor Responsibilities:

- Notify Risk and Insurance immediately (778-6474) and provide the employees name, brief injury description, employees contact information and treatment facility, if applicable.
- Review the packet as submitted by the employee and ensure it is completed in full and signed where appropriate. Ensure all forms are returned, including:
  - ✓ the C-3 "Employee Claim"
  - ✓ WC Form 1 – Claimant's Statement of Accident
  - ✓ WC Form 2 – Supervisor's Statement
  - ✓ WC Form 3 – Additional Witness Statements, if applicable
  - ✓ WC Form 4 – Authorization to release records
  - ✓ WC Form 5 – Notice to Employees applying for workers' compensation
- Notify Risk & Insurance immediately via phone or email with any change in work status and fax all physicians reports or doctors notes to (607) 778-2918. If you have any questions regarding this paperwork or any additional information regarding this claim, please call 778-6474.

Instructions

WORKERS' COMPENSATION BOARD
New York State

Employee Claim

State of New York - Workers' Compensation Board

C-3

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ (First / MI / Last) 2. Date of Birth: _____/_____/_____

3. Mailing address: _____ (Number and Street/PO Box / City / State / Zip Code)

4. Social Security Number: ___-___-_____ 5. Phone Number: (____)_____ 6. Gender: ☐ Male ☐ Female

7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____)_____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: _____/_____/_____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: _____/_____/_____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: _____ **DATE OF INJURY/ILLNESS:** _____/_____/_____
First MI Last

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
   If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
   If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____
   _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
    If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: _____/_____/_____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____
    _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? _____/_____/_____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? _____/_____/_____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? _____/_____/_____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
   ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
   Name and address where you were first treated: _____
   _____ Phone Number: (_____)_____
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
   Give the name and address of the doctor(s) treating you for this injury/illness: _____
   _____ Phone Number: (_____)_____
5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
   If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
   _____
   _____
   _____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
   If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: _____/_____/_____

On behalf of Employee: _____ Print Name: _____ Date: _____/_____/_____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: _____/_____/_____

Print Name: _____ Title: _____

ID No., if any: **R** _____ If Licensed Representative, License No.: _____ Expiration Date: _____/_____/_____

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CLAIMANT'S STATEMENT

Person Injured _____ Social Security# _____
(Last Name) (First Name) (Initial)

Date of Birth _____ Date of Hire _____ Job Title _____

Home Address _____

Phone Number _____ Department Employed By _____

Date of Incident _____ Hour began work _____ AM PM Time of Injury _____ AM PM

Exact Location of Incident _____ Medical Treatment: ☐ Yes ☐ No

Property/Equipment Involved _____

Describe exactly what happened (attach additional pages if necessary) _____

Body Part injured (Be specific to right or left) _____

Witnesses to Incident Witness Department Witness Contact information

Attach additional pages if needed

Illness Cases Only ☐ Check this box if the employee independently and voluntarily requests that his or her name not be entered on the log. If checked, treat as a privacy concern case

My signature affirms and certifies that the information I have provided is true and accurate, that no false statements or representations or material omissions have been made in support of any claim for payment, and that I understand that that this document will be presented to an insurer and become a part of the records of Broome County.

_____ _____
Signature and title of person preparing report **Date**

SUPERVISOR/DEPARTMENT HEAD STATEMENT

Please attach additional pages, if necessary

Injured Employee's Name _____ Supervisors name _____

Date notified of Injury _____ Time notified _____ AM PM

Did you witness the Accident/Injury? ☐ Yes ☐ No

If yes, please describe the incident/accident in detail as witnessed along with employee's condition after injury _____

If No, please state the claimant's account of the injury and your observation of their condition at the time of reporting (i.e limping, cut, bruised, etc)

Do you agree with the claimant's statement of injury? ☐ Yes ☐ No

If you do not agree with the statement of injury, please explain: _____

Was Personal Protective Equipment required ☐ Yes ☐ No If Yes, was it used properly ☐ Yes ☐ No

Please list any unsafe conditions or hazards that caused/contributed to this incident _____

Please note any precautions that should be taken to prevent a similar injury in the future _____

SIGNATURE OF SUPERVISOR **DATE**

SIGNATURE OF DEPARTMENT HEAD **DATE**

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WITNESS STATEMENT

(Each witness must complete a separate statement)
Attach additional pages, if necessary

Injured Employee's Name _____

Date of Accident/Incident _____ Time of Incident_____ AM PM

Location of Incident _____

Witness Name_____ Witness Job Title_____

Witness Department_____ Witness Phone Number_____

Witness Description of Incident (Include as much detail as possible): _____
(attach an additional page if necessary)

_____

_____

_____

_____

_____

_____

_____

_____

My signature affirms and certifies that the information I have provided is true and accurate, that no false statements or representations or material omissions have been made in support of any claim for payment, and that I understand that this document will be presented to an insurer and become a part of the records of Broome County.

_____ _____
Witness Signature Date Signed

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

MUST BE SIGNED FOR PAYMENT OF MEDICAL BILLS

I, _____ authorize the use and disclosure of Health Information as described in this authorization.
Print Name

Specific person/organization or class of persons authorized to provide information:

Licensed physician, medical practitioner, nurse, pharmacist, hospital, clinic, other medical or medically-related facility, insurance or reinsurance company, consumer reporting agency, employer or former employer.

Specific person/organization authorized to receive and use information:

Broome County and legal representatives, Triad Group (or current TPA) and Corporate Care Management, Inc (or current Nurse Case Management Firm)

Specific and meaningful description of the information:

Any and all office notes, diagnostic test results, x-rays, employment records and hospital records.

Purpose of the request:

To evaluate the claim for Workers' Compensation Benefits, to determine causal relationship and/or apportionment.

Right to Revoke:

I understand that I have the right to revoke this authorization at any time by notifying Broome County Office of Risk & Insurance, P.O. Box 1766, Binghamton, NY 13902 in writing. I understand that this revocation is only effective after it is received and logged in by Broome County Office of Risk & Insurance or the current TPA. I understand that this revocation will not apply to any use or disclosure made prior to its activation by Broome County.

I understand that after this information is disclosed, federal law may not protect it and the recipient may re-disclose it for the purposes stated above.

I understand that failure to sign this authorization could result in delayed processing of my claim and the Carrier's inability to pay related medical expenses.

I understand that I may receive a copy of this authorization.

I understand that this authorization will remain in effect for the entire period of my Workers' Compensation claim unless revoked.

Signature of Claimant: _____ Date of Birth: _____

Department employed by: _____ Date: _____

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NOTICE TO EMPLOYEES APPLYING FOR WORKERS' COMPENSATION BENEFITS

If you are applying for or are receiving workers' compensation benefits (including advanced payments of workers compensation in the form of sick, vacation or any other benefit time), you must immediately report any other earnings you receive to the Broome County Office of Risk & Insurance and the Workers' Compensation Board including but not limited to:

1. If you return to any form of work
2. If you held employment of any kind with any other employer at the time of your injury
3. If you are self employed
4. If you receive income from any other sources such as rental property, online sales, etc.
5. If you perform any services in exchange for other goods or services, including volunteer work
6. If there is a change in your contact information including phone number and address
7. If you are participating in any type of educational classes or vocational rehabilitation programs

Failure to report earnings as defined will subject you to criminal prosecution and civil liability, including the suspension or forfeiture of your benefits.

Your endorsement on a benefit check, or deposit of the check into an account, is your statement that you are entitled to receive workers' compensation benefits. Your signature on a benefit check is a further affirmation that you have made no false claims or statements or concealed any material fact regarding your workers' compensation claim.

My signature affirms and certifies that the information I have provided is true and accurate, that no false statements or representations or material omissions have been made in support of any claim for payment, and that I understand that this document will be presented to an insurer and become a part of the records of Broome County.

_____ _____

Date **Claimant Signature**

_____

Print Name

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Treating Physician's Workers' Compensation Report

To the employee: You must give this form to your physician at each visit

EMPLOYEE NAME _____

DEPT. AND DIVISION _____

DATE OF INJURY

For Physician use only

- In your medical opinion is this injury related to the individual's job? ☐ Yes ☐ No
- Current degree of disability ☐ Mild (25%) ☐ Moderate (50%) ☐ Marked (75%) ☐ Total (100%)
- Taking into consideration the degree of disability you identified the employee:

☐ Can return to work without restrictions ___/___/___ ☐ Cannot return to work until ___/___/___

☐ Return to work with restrictions indicated below effective ___/___/___ through ___/___/___

Broome County has a comprehensive modified duty program & can accommodate most restrictions. The information provided in this form will be utilized to temporarily assign county employees to modified duty. Please explain in detail in the "Additional Comments" the nature of your patient's limitation in terms of Hours / Weight. / Range of Motion, etc.

				Additional Comments
☐ NO	☐ LIMITED	☐ UNRESTRICTED	PUSHING	
☐ NO	☐ LIMITED	☐ UNRESTRICTED	PULLING	
☐ NO	☐ LIMITED	☐ UNRESTRICTED	BENDING	
☐ NO	☐ LIMITED	☐ UNRESTRICTED	STOOPING	
☐ NO	☐ LIMITED	☐ UNRESTRICTED	SITTING	
☐ NO	☐ LIMITED	☐ UNRESTRICTED	STANDING	
☐ NO	☐ LIMITED	☐ UNRESTRICTED	TWISTING	
☐ NO	☐ LIMITED	☐ UNRESTRICTED	CLIMBING	
☐ NO	☐ LIMITED	☐ UNRESTRICTED	KNEELING	
☐ NO	☐ LIMITED	☐ UNRESTRICTED	LIFTING	_____ Lbs. Max.
☐ NO	☐ LIMITED	☐ UNRESTRICTED	**OVERHEAD** LIFTING	_____ Lbs. Max.

Additional restrictions:

Authorization for the following treatment/test is hereby requested:
Requests can be faxed to (607) 778-2918 Attn: Colleen _____

Date of this Exam: _____ Date of Next Appointment: _____

Physician Signature, Address and Phone Number: _____

I acknowledge and agree to the restrictions as marked above: _____
CLAIMANT'S SIGNATURE REQUIRED