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 March 6, 2014
PINK PACKET

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

2. **VAW-2 – New York State Employee claim form** to be completed by Volunteer.

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.

9. **Cypress Care First Fill Information Form** – to be retained by the claimant and taken to the pharmacy if any medication is prescribed for the injury.

Forms VAW-2, 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

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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, signed and returned to Risk & Insurance within 5 days. Please make sure all forms are fully completed and signed or Risk & Insurance will return them for improper completion.
3. Retain the Pharmacy benefits form, WC Form 6-Treating physicians report and a copy of the packet, for your records.
4. All requests for Diagnostic Testing must be scheduled through our Network. **Failure to schedule through the appropriate network, will result in refusal of payment. All requests for treatment should be faxed to (607) 778-2918, Attention: Workers' Compensation.**
5. **Billing information**: **The employee is responsible** for notifying the physician of the proper billing information. Be sure to mark the date of injury clearly on all correspondence and make sure all bills are sent to: **Broome County Office of Risk & Insurance Management, P.O. Box 1766, Binghamton, NY 13902-1766.** The treating physicians report must be taken to any and all physician appointments.
6. **Do not pay for Prescriptions!** Information regarding the pharmacy benefits manager is attached and must be provided to the pharmacy with your initial fill.
7. If you have any questions regarding your claim, please call Risk & Insurance at 778-6474.

Supervisor Responsibilities:

- If this is a serious injury and requires transport to a hospital or more than one day out of work, call Risk and Insurance immediately and provide the employees name, brief injury description, employees contact information and treatment facility.
- 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 VAW-2 "Injury to Volunteer Ambulance Worker"
  - ✓ 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

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

POLITICAL SUBDIVISION'S REPORT OF INJURY TO VOLUNTEER AMBULANCE WORKER

Send this Report directly to Chair, Workers' Compensation Board at address shown on reverse side within ten (10) days after injury is incurred. Answer all questions fully. Copy also should be provided to or retained by your insurance carrier.

Any political subdivision that fails to timely file Form VAW-2, as required by Section 110 of the Workers' Compensation Law and Section 42 of the Volunteer Ambulance Workers' Benefit Law, shall be subject to a fine of not more than $1,000. In addition, the Board or Chair may impose a penalty of up to $2,500.

TYPEWRITER PREPARATION IS STRONGLY RECOMMENDED - INCLUDE ZIP CODE IN ALL ADDRESSES-VOLUNTEER AMBULANCE WORKER'S S.S.NO. MUST BE ENTERED

WCB CASE NO.(If Known)	CARRIER CASE NO.	CARRIER CODE NO.	VAW POLICY NO.	SOCIAL SECURITY NO.
		W-806004		

	NAME	ADDRESS
1. POLITICAL SUBDIVISION OR AMBULANCE DISTRICT		
2. AMBULANCE COMPANY		
3. INSURANCE CARRIER IF ANY	Broome County Self Insurance Plan	PO Box 1766 Binghamton, NY 13902

INJURED PERSON

4. NAME AND ADDRESS OF VOLUNTEER AMBULANCE WORKER

5. (a) SEX

5. (b) DATE OF BIRTH month day year

6. NAME AND ADDRESS OF REGULAR EMPLOYER

7. HAS INJURED AMBULANCE WORKER RETURNED TO REGULAR EMPLOYMENT ☐ Yes ☐ No

INJURY

8. WHERE DID INJURY OCCUR? (Specify in building, outside building, en route in ambulance, etc.)

9. CHECK ONE: ☐ THE ABOVE-NAMED VOLUNTEER AMBULANCE WORKER WAS INJURED IN THE LINE OF DUTY WHILE SERVING WITH HIS/HER OWN AMBULANCE COMPANY OR AMBULANCE DEPARTMENT. ☐ THE ABOVE-NAMED VOLUNTEER, MEMBER OF ANOTHER AMBULANCE DEPARTMENT, WAS INJURED IN LINE OF DUTY AFTER HIS/HER SERVICES HAD BEEN ACCEPTED BY THE ABOVE-NAMED AMBULANCE COMPANY OR DEPARTMENT.

10. DATE OF INJURY

11. DATE DISABILITY BEGAN

12. DATE OF FIRST KNOWLEDGE OF INJURY

13. WAS NOTICE OF INJURY GIVEN IN WRITING ☐ Yes ☐ No

14. ADDRESS WHERE INJURY OCCURRED

15. NAMES AND ADDRESSES OF WITNESSES (Attach separate sheet if necessary.)

16. NATURE OF INJURY AND PART(S) OF BODY AFFECTED: (e.g., "INJURY TO CHEST", etc.)

17. DID YOU PROVIDE MEDICAL CARE? ☐ Yes ☐ No

IF YES, WHEN

18. (a) NAME AND ADDRESS OF DOCTOR

(b) NAME AND ADDRESS OF HOSPITAL

CAUSE OF INJURY

19. WHAT WAS AMBULANCE WORKER DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material ambulance worker was using.)

20. HOW DID THE INJURY OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.)

21. (a) WAS PROTECTIVE EQUIPMENT PROVIDED. (Such as gas mask, etc.) ☐ Yes ☐ No (b) WAS PROTECTIVE EQUIPMENT IN USE AT THE TIME? ☐ Yes ☐ No

(c) WAS PROTECTIVE EQUIPMENT DEFECTIVE? ☐ Yes ☐ No IF YES, IN WHAT WAY (Attach separate sheet if necessary.)

FATAL CASES

22. (a) DATE OF DEATH

(b) NAME AND ADDRESS OF NEAREST RELATIVE

(c) RELATIONSHIP

PREPARATION

DATE OF THIS REPORT

IF FORM IS SUBMITTED BY POLITICAL SUBDIVISION, COMPLETE A & B BELOW.
IF FORM IS SUBMITTED BY THIRD PARTY, COMPLETE A,B,C & D BELOW.

A. PERSON PREPARING FORM OR SUPPLYING INFORMATION TO THIRD PARTY

B. TITLE

TELEPHONE NUMBER & EXTENSION

C. IF REPORT PREPARED BY THIRD PARTY, COMPANY NAME AND ADDRESS

D. THIRD PARTY CONTACT NAME

TELEPHONE NUMBER & EXTENSION

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CLAIMANT'S STATEMENT

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

Home Address _____

Phone Number _____ Department _____

Date of Incident _____ Time of Incident _____ AM PM Job Title _____

Exact Location of Incident _____

Property/Equipment Involved _____

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

Describe any Injuries in Detail
(attach additional pages if needed) _____

Witnesses to Incident	Witness Department	Witness Contact information

Attach additional pages if needed

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

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

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, POMCO, Inc (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

First Fill Information
Pomco Group

CYPRESS CARE
A Healthcare Solutions Company

Dear Injured Worker,

Cypress Care has been selected by **Pomco Group** to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply **fill in the form below** and present it at the pharmacy at the time your prescription is filled. This form should ensure that you will have no out-of-pocket expenses when you fill your first prescription.

For your convenience, Cypress Care has an extensive network of retail pharmacies including major chain drug stores.

For pharmacy locations, you may call our toll-free number or visit our website at **www.cypresscare.com** and use the pharmacy locator in the quick links section of the home page.

If you have any questions, or would like to learn about our convenient home delivery service, please call our customer

Estimado Trabajador(a) Lesionado(a),

Cypress Care ha sido seleccionado por **Pomco Group** para asistirle en la obtención de medicamentos relacionados con su reclamo de compensación de trabajadores. Este formulario le permite completar las prescripciones escritas por el médico de sus empleados autorizados de compensación para los medicamentos relacionados con su lesión. Simplemente **llene el siguiente formulario** y preséntelo en la farmacia en el momento que su prescripción está lleno. Este formulario debe asegurarse de que usted no tendrá gastos de su propio bolsillo cuando surte su primera receta.

Para su comodidad, Cypress Care cuenta con una extensa red de farmacias al por menor. De la red de farmacias Cypress Care incluye las siguientes principales cadena de farmacias:

Para localidades de Farmacia adicional, también puede llamar a nuestro número gratuito o visite nuestro sitio web en **www.cypresscare.com** y usar el localizador de farmacias en la sección de enlaces rápidos de la página de inicio.

Si usted tiene alguna pregunta, o le gustaría aprender acerca de nuestro conveniente servicio al domicilio, llame a nuestro número gratuito de servicio al cliente: **800.419.7191**.

First Fill Form: Complete and take to your pharmacy

Bin #: 010876 **Group Number:** BROOME

Member ID:		Last 4 digits of SSN + date of injury; No spaces (i.e. 9999050206)
Member Name:		Injured worker's first & last name
Employer Name:		
Date of Injury:		

Pharmacy Help Desk: 800.419.7191

PLEASE NOTE: This form allows you to fill your initial prescriptions with a cost maximum of $150 per prescription and no more than a 10-day supply per prescription. Once your claim has been reviewed, you will be sent a new card in the mail. If you do not receive the pharmacy card, please call us at 800.419.7191.

Issuance of this letter does not constitute acceptance of your claim.