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
P.O. Box 1766, Binghamton, NY 13902 www.gobroomecounty.com
Main Office: Phone (607)778-6474 Fax: (607)778-2918

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

STATE OF NEW YORK-WORKERS' COMPENSATION BOARD

POLITICAL SUBDIVISION'S REPORT OF INJURY TO VOLUNTEER FIREFIGHTER

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 VF-2, as required by Section 110 of the Workers' Compensation Law and Section 42 of the Volunteer Firefighters' 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 FIREFIGHTER'S S.S.NO. MUST BE ENTERED BELOW

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

NAME		ADDRESS
1. POLITICAL SUBDIVISION OR FIRE DISTRICT		
2. FIRE 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 FIREFIGHTER

5.(a) SEX

5.(b) DATE OF BIRTH month day year

6.NAME AND ADDRESS OF REGULAR EMPLOYER

7. HAS INJURED FIREFIGHTER RETURNED TO REGULAR EMPLOYMENT ☐ Yes ☐ No

INJURY

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

9. CHECK ONE: ☐ THE ABOVE-NAMED VOLUNTEER FIREFIGHTER WAS INJURED IN THE LINE OF DUTY WHILE SERVING WITH HIS/HER OWN FIRE COMPANY OR FIRE DEPARTMENT. ☐ THE ABOVE-NAMED VOLUNTEER FIREFIGHTER, MEMBER OF ANOTHER FIRE DEPARTMENT, WAS INJURED IN LINE OF DUTY AFTER HIS/HER SERVICES HAD BEEN ACCEPTED BY THE ABOVE-NAMED FIRE COMPANY OR FIRE 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? Ye ☐ No ☐ IF YES, WHEN

18. (a) NAME AND ADDRESS OF DOCTOR

(b) NAME AND ADDRESS OF HOSPITAL

CAUSE OF INJURY

19. WHAT WAS FIREFIGHTER DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material firefighter 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 S, 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

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

VOLUNTEER FIREFIGHTER ACCIDENT REPORT

Answer all questions fully. Attach additional sheets as needed.

Firefighter's Nam _____ SSN: _____

Date of accident: _____ Approximate time: _____ Hour began work _____

Birthdate: _____ Fire Department and Municipality: _____

Where did the accident happen? _____

What job duty were you performing when you were hurt? _____

Describe in detail how you were injured: _____

_____

Body Part Injured (Specify Left or Right): _____

Type of Injury (i.e. bruise, cut, break, etc): _____

Please list witness's to the accident: _____

Were you wearing required Protective Equipment? (e.g. safety glasses, gloves, etc.) ☐Yes ☐No

Did you go to the Emergency Room? ☐Yes ☐No If yes, provide:

Hospital: _____ Were you hospitalized overnight? ☐Yes ☐No

Did you see another doctor? ☐Yes ☐No If yes, provide:

Physician name and address: _____

It is a crime punishable as a Class A Misdemeanor under the laws of the State of New York for a person in and by a written instrument to knowingly make a false statement or to make a statement which such person does not believe to be true.

➔ _____ _____

Employee Signature **Date Completed**

To be completed by Supervisor

Date Supervisor notified: _____ Supervisor's Name (print): _____

Was volunteer following proper procedure and wearing appropriate PPE? ☐Yes ☐No

If no, please explain: _____

I agree/disagree (circle one) with the volunteer's statement

_____

Supervisor Signature and Date

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

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

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)778-6474 Fax: (607)778-2918

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: _____

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)778-6474 Fax: (607)778-2918

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

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)778-6474 Fax: (607)778-2918

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