

# WORKER'S COMPENSATION PAPERWORK PROCEDURES WALWORTH COUNTY

## INSTRUCTIONS FOR EMPLOYEE

We are sorry you have sustained an injury or illness. By using the forms in this packet and following this outline of simple procedures, Walworth County and WMMIC, our third party administrator for Worker's Compensation, hope to ensure prompt processing of your claim. In this packet you will find the following forms:

Employee's Accident Report  
Authorization to Disclose Health Information  
Walworth County Return to Work Form  
Introductory Letter to Medical Provider  
Mileage Log

### Instructions

1. You will need to notify your supervisor immediately after the accident/injury or onset of illness and complete the attached Employee Accident Report. Review your Accident Report with your supervisor as soon as possible after you have completed it. (Within 24 hours or next business day)
2. If you require medical treatment you should take an Authorization to Disclose Health Information form and Return to Work form with you when seeking treatment. You are required to complete the authorization and present it to your doctor; a copy is to be forwarded to the Human Resources Privacy Contact. The Return to Work form is to be completed by the treating physician every time you see him/her. Submit the completed/signed medical report to your supervisor as soon as possible after each medical treatment visit. (Within 24 hours or the next business day)
3. As our third party administrator, WMMIC will be reviewing your claim for compensability under the Worker's Compensation Act. A claims adjuster from WMMIC may contact you by phone or in person to follow up on your injury or illness. In some cases they may ask you to make a formal taped statement regarding your accident or illness. This is normal procedure for insurance claims and is done as part of their administration of our worker's compensation fund. In addition, the claims adjuster may contact your treating practitioner for more information to assist them in determining compensability, your availability for restricted work, etc.
4. WMMIC will be processing all medical bills and mileage associated with your claim. In order to receive reimbursement or have your medical bills paid in a timely manner WMMIC requires a doctor's note from each of your medical visits. Please let your treating physician know this and ask them for their cooperation in providing this information at the time they submit their bills for payment. An introductory letter is part of this packet and you need to give this to the doctor's office for their billing records. For reimbursement of mileage, you must complete a Mileage Log.
5. If you have any questions regarding the worker's compensation process or your claim in particular, please contact Human Resources at 741-7950.

PLEASE PRINT

Employee Name (Last First, Middle)	Employee Address (Street City, Zip Code)
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Home Telephone	Date of Birth	Approx. Length of Time in Position	Job Title
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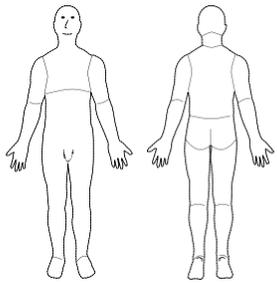
What Happened? What Were You Doing? How Did It Occur? (Be Specific)

When Did You Report the Incident? (Date/Time)	Who Did You Report the Incident To?	How Was the Incident Reported? (In person, phone call, email, note etc.)
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**WHERE & WHEN DID THE ACCIDENT HAPPEN? (Be Specific)**

Location	Date	Time	A.M. P.M.	Were you on duty?	Identification of Equipment Involved
Name(s) of other party(ies) involved, if a motor vehicle accident occurred			Identify any protective equipment you were using at the time of the incident		
Name(s) of Witness(es)			If the incident occurred outside, please describe conditions. (windy, rainy etc.)		

<b>ACCIDENT TYPE (Check Related Item)</b> <input type="checkbox"/> Struck Against or By <input type="checkbox"/> Fall <input type="checkbox"/> Caught In <input type="checkbox"/> Punctured <input type="checkbox"/> Lifting/Carrying <input type="checkbox"/> Pulling/Pushing <input type="checkbox"/> Throwing <input type="checkbox"/> Struggle w/person <input type="checkbox"/> Contact w/Electric Current <input type="checkbox"/> Contact w/Temperature Extreme <input type="checkbox"/> Inhalation of Toxic Substance <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Other: (specify) _____	<b>INJURY TYPE (Check Related Item)</b> <input type="checkbox"/> Amputation <input type="checkbox"/> Asphyxia <input type="checkbox"/> Burn or Scald <input type="checkbox"/> Chemical Burn <input type="checkbox"/> Concussion <input type="checkbox"/> Contusion <input type="checkbox"/> Laceration <input type="checkbox"/> Dermatitis (also Poison Ivy) <input type="checkbox"/> Dislocation <input type="checkbox"/> Electric Shock	<input type="checkbox"/> Fracture <input type="checkbox"/> Frostbite <input type="checkbox"/> Hypothermia/Freezing <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Hernia <input type="checkbox"/> Irritation - Joints <input type="checkbox"/> Poisoning - Systematic <input type="checkbox"/> Foreign Body <input type="checkbox"/> Insect Bite <input type="checkbox"/> Sprains, Strains <input type="checkbox"/> Multiple Injuries <input type="checkbox"/> Other: (specify) _____
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<b>BODY PART (Check ALL affected part[s])</b>			<b>AND:</b>		<b>(Circle Appropriate Body Part)</b>
<b>Head</b> <input type="checkbox"/> Eye <input type="checkbox"/> Ear <input type="checkbox"/> Jaw <input type="checkbox"/> Facial <input type="checkbox"/> Nose <input type="checkbox"/> Skull <input type="checkbox"/> Head	<b>Trunk</b> <input type="checkbox"/> Neck/Upper Back <input type="checkbox"/> Mid-Back <input type="checkbox"/> Lower Back <input type="checkbox"/> Chest <input type="checkbox"/> Lungs <input type="checkbox"/> Abdomen <input type="checkbox"/> Hips	<b>Extremities (Indicate Left or Right)</b> <input type="checkbox"/> Finger <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Forearm <input type="checkbox"/> Elbow <input type="checkbox"/> Upper Arm <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper Extrem. Multiple	<input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Calf <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Toe <input type="checkbox"/> Lower Extrem. Multiple		

**MEDICAL TREATMENT (Check Appropriate Item)**

<input type="checkbox"/> Sought Medical Treatment Immediately Where? Doctor/Practitioner Name?	<input type="checkbox"/> Scheduled Appointment w/Family Physician/Chiropractor Where? Doctor/Practitioner Name?	<input type="checkbox"/> Did Not Seek Medical Treatment
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COMMENTS:

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I have completed the above information to the best of my ability. I understand that any deliberate false statements made in the filing of a worker's compensation claim may result in discipline up to and including discharge. I agree to full medical and investigative disclosure pertinent to this incident. I understand that the purpose of this release is to enable Walworth County staff or representative to determine eligibility for Worker's Compensation consideration.

Employee Signature	Date Signed
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**WALWORTH COUNTY**  
**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

**Purpose:** This form is used for an individual to authorize use or disclosure of the individual's protected health information (PHI) for the purposes stated. The individual's authorization to use or disclose PHI is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

**Section A: Psychotherapy notes.**

Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, it must not be used as an authorization for any other type of protected health information

**Section B: Individual authorizing use and or disclosure.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City/State \_\_\_\_\_ ZIP \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Identification Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**TO THE INDIVIDUAL: Please read the following and complete the information requested.**

**No Conditions:** This authorization is voluntary. Your enrollment in a health plan or eligibility for health plan benefits cannot be conditioned on receiving this authorization.

**Employer-required medical certification.** Medical certification may be required by the employer as a condition of determining an employee's eligibility for employment or for other benefits not covered by HIPAA. The individual's choice to not authorize use or disclosure of PHI may adversely affect the individual's access to non-HIPAA employment or benefits.

**Effect of Granting this Authorization.** The protected health information described below may be disclosed to and/or received by persons or organizations who are not subject to federal health information privacy laws. These persons or organizations may further disclose the PHI, and it may no longer be protected by federal health information privacy laws.

**Section C: The use or disclosure being authorized.**

This authorization is made at the request of individual (or the individual's personal representative), for the following purposes:

- |   |   |
|---|---|
| <input type="checkbox"/> Payment of claims                          | <input type="checkbox"/> Worker's compensation claim adjudication   |
| <input type="checkbox"/> Claims adjudication                        | <input type="checkbox"/> Return to work or light-duty determination   |
| <input type="checkbox"/> Family/Medical Leave medical certification | <input type="checkbox"/> Eligibility for employment (pre-employment or post-offer job offer made conditional on results of medical examination) |
| <input type="checkbox"/> Sick leave medical certification           | <input type="checkbox"/> Employer-required substance abuse testing  |
| <input type="checkbox"/> Disability leave determination             | <input type="checkbox"/> Occupational health and safety requirement   |
| <input type="checkbox"/> ADA reasonable accommodation determination |   |
| <input type="checkbox"/> Other _____                                |   |

WALWORTH COUNTY

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION (PAGE 2)

Protected Health Information to Be Used and/or Disclosed. Specifically and meaningfully describe the PHI that this authorization will allow to be used or disclosed:

- Health care claims
Health care payment or remittance advice
Coordination of benefits
Health care claim status
Enrollment or disenrollment in a health plan
Coverage or benefit determination
Health plan premium payments
Other (specify)
Medical records, as follows:
Medications from (dates)
Treatment from (dates)
Lab results from (dates)
X-ray/imaging reports from Dr.
Consultation reports from Dr.
Entire record from (dates)
Psychotherapy notes (dates)

Entities Authorized to Use or Disclose. The following individual or organization is authorized to use or disclose the PHI described above:

Name:
Address: City/State ZIP

Entities Authorized to Receive and Use. The following individual or organization is authorized to receive and use the PHI described above:

Name:
Address: City/State ZIP

Section D: Expiration and revocation.

Expiration: This authorization will expire (complete one):

- On (date)
On occurrence of the following event. The event must relate to the individual or to the purpose for the use or disclosure being authorized):

Right to Revoke: You may revoke this authorization at any time by giving written notice of revocation to the Privacy Contact listed below. Revocation of this authorization will not affect any action we took in reliance on this authorization before we received your written notice of revocation:

Privacy Contact: Walworth County Human Resources Department
Dale Wilson, Privacy Contact
P.O. Box 1001
Elkhorn, WI 53121
(262) 741-7965
E-mail: dwilson@co.walworth.wi.us

INDIVIDUAL'S SIGNATURE

I, , have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Signature: Date:

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Representative's Name Relationship

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Retain copy of this authorization in the individual's records and send one copy to the Human Resources Privacy Contact.

**WALWORTH COUNTY RETURN TO WORK FORM**  
**Worker Compensation Fitness for Duty Authorization**

This form is to assist **Walworth County** to place injured workers into suitable work within the limitations prescribed by the Medical Provider

**LIGHT DUTY WORK FOR WALWORTH COUNTY IS AVAILABLE FOR MOST CONDITIONS. IT IS ASSIGNED WITH THE WORK RESTRICTIONS BELOW.**

Walworth County Human Resources (262) 741-7950 • FAX: (262) 741-7948

Date/Time of Visit: \_\_\_\_\_

Next physician's appointment:  
Date: \_\_\_\_\_ Time: \_\_\_\_\_

Next therapy appointment:  
Date: \_\_\_\_\_ Time: \_\_\_\_\_

PATIENT'S NAME:
CLINIC OR HOSPITAL NAME/ADDRESS:
DATE OF INJURY/ILLNESS:

Diagnosis: \_\_\_\_\_

The patient whose name appears in the boxed area was seen for:

- Treatment of Initial Injury/Illness
- Follow-up Care for a Previously Reported Injury/Illness

The patient is:

- DISCHARGED FROM CARE**
- Able to Return to Full Work on (Date) \_\_\_\_\_  Is Working
- Unable to Work From \_\_\_\_\_ Through \_\_\_\_\_

Because of: \_\_\_\_\_

- Able to Return to Limited Work (See Work Limitations Below)  
From \_\_\_\_\_ Through \_\_\_\_\_

Medication Restrictions:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| <input type="checkbox"/> Must Take Prescription Medication(s)                        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| <input type="checkbox"/> Advised to Take Over the Counter Medication(s)              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| <input type="checkbox"/> Medication May Make Drowsy (Possible Safety/Driving Issues) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Work Limitations:

- Restricted Lifting
  - Pushing, Pulling
- |                             |                             |                             |                             |                             |  |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|--|
| MAXIMUM WEIGHT IN POUNDS    |                             |                             |                             |                             |  |
| <input type="checkbox"/> 10 | <input type="checkbox"/> 20 | <input type="checkbox"/> 30 | <input type="checkbox"/> 40 | <input type="checkbox"/> 50 |  |

- Restricted Bending
- |                              |                              |                               |                                |
|------------------------------|------------------------------|-------------------------------|--------------------------------|
| MAXIMUM NO TIMES PER HOUR    |                              |                               |                                |
| <input type="checkbox"/> 0-2 | <input type="checkbox"/> 2-6 | <input type="checkbox"/> 6-10 | <input type="checkbox"/> 10-20 |

- |                                |                                |                               |
|--------------------------------|--------------------------------|-------------------------------|
| DEGREE OF BEND                 |                                |                               |
| <input type="checkbox"/> 10-20 | <input type="checkbox"/> 20-45 | <input type="checkbox"/> Full |

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> No Climbing or Overhead Work          | <input type="checkbox"/> Right Hand Work Only | <input type="checkbox"/> No Repetitive Motions of:<br><input type="checkbox"/> 1. Hand Grasp<br><input type="checkbox"/> 2. Wrist Motion<br><input type="checkbox"/> 3. Elbow Flexion<br><input type="checkbox"/> 4. Foot Controls |
| <input type="checkbox"/> No Operation of Heavy Equipment       | <input type="checkbox"/> Left Hand Work Only  |  |
| <input type="checkbox"/> No Operation of Moving Equipment      | <input type="checkbox"/> Sitting Job Only     |  |
| <input type="checkbox"/> Sit/Stretch Breaks of _____ per _____ |   |  |

Other Limitations: \_\_\_\_\_

Comments: \_\_\_\_\_

## NOTICE TO MEDICAL PROVIDER

Dear Practitioner:

Our employee is seeing you for an alleged work related injury/illness. Please note that at the time of this examination, compensability may not have been determined. We ask that you complete the attached Return to Work form the employee provides you at the time of their visit. This form will assist our third party administrator, WMMIC, in their determination of compensability and provide the medical information for Walworth County to use in developing a light-duty assignment for the employee during their healing period.

All billing should be forwarded directly to WMMIC. Their address appears below:

WMMIC  
4785 Hayes Road  
Madison, WI 53704-7364  
ph: 608.245.6891  
fax: 608.852.8647

If you have any questions, please feel free to contact Human Resources at (262) 741-7950.

# WALWORTH COUNTY MILEAGE LOG

forward to:  
**WMMIC**  
 4785 Hayes Road  
 Madison, WI 53704

Name: \_\_\_\_\_

Address: \_\_\_\_\_

DATE: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

Exact From and To addresses needed for verification of mileage.

**No. of Miles**

DATE: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

Exact From and To addresses needed for verification of mileage.

DATE: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

Exact From and To addresses needed for verification of mileage.

DATE: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

Exact From and To addresses needed for verification of mileage.

DATE: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

Exact From and To addresses needed for verification of mileage.

DATE: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

Exact From and To addresses needed for verification of mileage.

DATE: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

Exact From and To addresses needed for verification of mileage.

**Employee Signature** \_\_\_\_\_

If form is not properly filled out with complete address, it will be returned to employee for this information