Goodwill
Northwest North Carolina

Reporting an Injury/Illness:

You and your supervisor contact Medcor by telephone to report the injury. The nurse triage team may give you self-care instructions, or may refer you to a provider. If referred to a provider, please take this packet and your drug test form with you.

MEDCOR's number: 1 (800) 775-5866

If you have continuing Medical Concerns:

If your situation worsens/does not improve, call Medcor again – DO NOT go to your own doctor. In an emergency, always call 9-1-1 and report to your manager ASAP.

Visiting a Medical Provider:

- Your first referral will be automatically authorized/paid for treatment.
- Give your provider the **LETTER OF INTRODUCTION TO PHYSICIAN** form included.
- Key Risk will contact you (generally within 48 hours).
- Key Risk **MUST** pre-authorize any additional treatment/visits in order for them to be paid.

Prescriptions: See any provider for prescriptions. Take the attached prescription sheet with you.

NEXT STEPS:

1. **Sign/Date and Return Authorization Forms (2) for Key Risk and Goodwill**
2. **Let your manager know immediately** of appointments or restriction changes.
3. **SCAN ALL MEDICAL NOTES TO**: Diana Inglis (dinglis@goodwillnwnc.org)
   (Goodwill needs immediate information related to return to work status.)

Goodwill Contact Information:

Human Resources is here to support you during your recovery.
Please call **Diana Inglis** (336) 724-3625 ext 1265 for any questions or needs.
SCAN AUTHORIZATIONS/ MED NOTES TO: dinglis@goodwillnwnc.org

Key Risk Contact Info/ Billing Information:

Key Risk is Goodwill's authorized Workers' Compensation provider. You may contact them if you have questions about authorization or claim status.
Key Risk - PO Box 8000, Daphne, AL 26526-8000 **866 847-8872**

INCLUDED IN PACKET: Key Risk Release/Authorization; Goodwill Release/Authorization; Physician Letter of Introduction; Prescription Information; Physician Report; Form 18

Key Risk
a Berkley Company

Please scan/email this authorization and Goodwill's authorization/agreement to Diana Inglis: dinglis@goodwillnwnc.org - she will forward to Key Risk.

Authorization

The undersigned has filed a claim for workers compensation benefits (hereafter referred to as the "Claim"). The amount and type of information sought pursuant to this authorization will depend upon the nature of the Claim, but will be used solely to facilitate determination regarding validity of the Claim and the payment of benefits or the administration of the insurance program under which the Claim has been made. Authorizing the disclosure of information is voluntary, and acceptance of the Claim will not be conditioned upon signing this authorization. This authorization is subject to revocation at any time, except to the extent that any party has already acted in reliance upon it. Any revocation must be submitted in writing to Key Risk, P.O. Box 8000, Daphne, AL 36526-8000.

The undersigned authorizes the release of information and communication between his or her health care provider(s) (including, without limitation, medical laboratories, pharmacies, pharmacy benefit managers, and medical suppliers) and representatives of Key Risk Management Services/Berkley Insurance Company ("Key Risk").

This release of information applies to all applicable medical records, medical information, bodily fluid and tissue samples, and benefit payment information with respect to any illness, injury, medical history, consultation, prescription, treatment, or benefit, and copies of all applicable records thereof, which may be appropriate or necessary throughout the course of this Claim. This authorization shall specifically include, but shall not be limited to, medical records, medical information and benefit payment information pertaining to or relating to the treatment of Acquired Immune Deficiency Syndrome, HIV, mental illness, and drug or alcohol related problems.

The undersigned also authorized the Social Security Administration and the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors, to release to Key Risk information concerning his or her workers compensation injury, entitlement dates and benefit amounts.

The undersigned further authorizes Key Risk to release any such information to its reinsurers, attorneys, second injury fund consultants, or to medical laboratories, medical peer review panels, CMS, state insurance or fraud agencies, managed care vendors, industry anti-fraud or law enforcement organizations, research and statistical reporting organizations, or the undersigned's employer and its excess insurer, to the extent that Key Risk considers doing so to be reasonably appropriate or necessary for the purposes of its administration of the Claim or the insurance program under which the Claim has been made.

Information disclosed to Key Risk is from records whose confidentiality is protected by various state or federal laws. Any further disclosure of this information may no longer be subject to certain protections provided under federal privacy regulations. Unless revoked earlier by the undersigned, in writing, this authorization shall be valid for three years after Key Risk has closed the Claim. A copy of this authorization is to be considered as valid as the original.

Employee Signature _____ **Date** _____

Employee Name _____ **Employer** _____
(Please Print) **(Please Print)**

Claim Number _____ **Date of Birth** _____

Please scan/email this authorization and Key Risk's authorization/agreement to Diana Inglis: dinglis@goodwillnwnc.org - she will forward Key Risk's agreement to them on your behalf.

Goodwill
Northwest North Carolina

AGREEMENT BETWEEN GOODWILL AND EMPLOYEE

TO ENSURE QUICK AND APPROPRIATE RETURN TO WORK

This is a voluntary agreement referencing injury/illness information which Goodwill is legally entitled to review. This agreement ensures that information is received quickly to facilitate your return to work.

This agreement is:

1. Between Goodwill (employer) and YOU (the employee).
2. Is SEPARATE from the Workers Compensation Carrier's agreement.
3. ONLY is relevant for the following information:
    - Physical or other restrictions for work duties
    - Return to work date
    - Upcoming medical dates or referral information (for follow-up on return to work)

Even without this agreement, it is YOUR responsibility as an employee to fax or scan the above information to Diana Inglis immediately after each appointment; however, there are cases in which a physician does not provide appropriate documentation to YOU (the employee) which can delay the process.

The Workers Compensation Carrier cannot provide this information quickly enough for Goodwill to ensure immediate and appropriate return to work, therefore it is important that Goodwill is able to contact the physician for information and clarification of the above information independently.

Agreement: Having filed a claim for workers compensation benefits, I (the employee) voluntarily authorize the release of any and all records related to the areas above to my employer, Goodwill Industries of Northwest NC, Inc.

_____

Employee Name

_____

Employee Signature

_____

Date

Key Risk
a Berkley Company

Letter of Introduction to the Physician

Date: _____

Name of Provider: _____

Street Address or P.O. Box: _____

City, State Zip: _____

Dear Provider:

_____, an employee of, _____, has reported a possible work related injury or illness. We have filed a workers compensation claim with our carrier, Key Risk. Any authorization for treatment or referrals for additional treatment must be directed to Key Risk's claim call center at **866.847.8872**.

Key Risk will be responsible for making all compensability decisions regarding this workers compensation claim. If the claim is compensable, all medical bills will be paid directly by Key Risk under our workers compensation policy. Therefore, please forward all medical bills and medical reports **(note: bills cannot be processed without the appropriate supporting medical reports)** directly to:

Key Risk
P.O. Box 8000
Daphne, AL 36526-8000

The injured employee understands that if the claim is found not to be a compensable claim, he or she will be responsible for all bills related to your treatment.

We appreciate your cooperation and assistance. If you have any questions, please contact Key Risk's client service call center at **866.847.8872.**

_____
(Employer)

_____
(Date)

PRINT SAVE AS

Key Risk
a Berkley Company

Physician's Report / Pharmacy Guide

MAILING ADDRESS: P.O. Box 49129, Greensboro, NC 27419
866.847.8872 www.keyrisk.com

EMPLOYER: Please complete the top section and give to the injured employee to take to his or her authorized treating physician. If you already have transitional duty job descriptions available, please attach a copy for the treating physician's review.

Name of Employee/Patient: **Last:** _____ **First:** _____

Date of Injury: _____

Name of Employer / Company: _____

Employer Signature: _____ Name of Doctor Chosen: _____

EMPLOYEE: Please take this form with you to an authorized treating physician. Please have the physician complete the middle section and return this immediately to your employer. The bottom section is for you to show the pharmacist should you need to have any prescriptions filled as prescribed by your authorized treating physician for this work related injury.

AUTHORIZED PHYSICIAN, PLEASE COMPLETE

Diagnosis: _____

A post accident drug test **has** been completed ☐ or ☐ **has not** been completed (check one)

In accordance with this patient's physical capability, check all that apply:

☐ May resume work immediately with no restrictions
☐ May resume work immediately with the following restrictions:

- ☐ Sedentary work (sitting, occasional walking, standing, lifting less than 10 pounds)
- ☐ Light work (lifting less than 20 pounds)
- ☐ Medium work (lifting less than 50 pounds)
- ☐ Heavy work (lifting less than 100 pounds)
- ☐ Normal shift
- ☐ Limited hours per day: ☐ 2 hours; ☐ 4 hours; ☐ 6 hours
- ☐ Other: _____

☐ Repetitive Motion Restrictions (specific to hand/arm injuries):

Frequency	Left	Right	Both
No Use	☐	☐	☐
Occasional <33% of time	☐	☐	☐
Frequent 34-66% of time	☐	☐	☐
Regular 67-100% of time	☐	☐	☐

☐ Patient may return to work at full duty on (date): _____
☐ Patient has a return appointment on (date): _____ at (time) _____

Please indicate any referrals that are required: _____

Physician's Signature | **Date** | **Physician's Name (type or print)**

Contact Key Risk's Claim Department at 866.847.8872 for authorization for the referral.

PHARMACIST: Process all prescriptions through ***Optum*** for this patient. Contact ***Optum*** at (800) 547-3330 to establish eligibility.

DO NOT CHARGE THE PATIENT FOR THE PRESCRIPTION

Walgreens	Leader Drug Stores	King Soopers	Food Lion	Pamida Pharmacy	Medicine Chest Pharmacies
CVS	K-Mart	Medicap Pharmacies	Dillon Pharmacies	Wegmans	Ross Park Pharmacy
Rite Aid	Ahold	Fred's Pharmacy	Life Check	Kinney Drugs	Northeast Pharmacy Services
Wal-Mart	The Medicine Shoppe	Brookshire's	United Supermarkets	Bioscrip	Brookshire Brothers Food & Pharmacy
Giant Eagle Pharmacies	Family Care	Albertsons/Sav-On	Smith's Pharmacy	Spartan Stores	OPTUM® Please call 800.547.3330 for additional participating pharmacies.
Kroger	Long's Drug Stores	Raley's	The Vons Companies	U Save Pharmacy	
Meijer	Bashas	Hannaford Brothers	Sav-Mor Drug Stores	Randall's Food & Drug	
Costco	Harris Teeter	Hy-Vee	Pavilion Plaza Pharmacy	Foodarama Supermarkets	
Publix Super Markets	Kerr Drug	Ingles Markets	Kash N' Karry	Unity Pharmacies	
Albertsons	Winn-Dixie Stores	Aurora Pharmacy	Supervalu	City Market	
Farm Fresh	Major Value	True Care	Perlmart	Thrifty White	
Access Health	RxPride	Save Mart Supermarkets	JH Harvey	Super D Drugs	Tom Thumb Randall's Food & Drug
Target	Safeway Pharmacies	Shopko Stores	Bi-Lo Pharmacy	K-VAT-T Food Stores	Pharmacy Express

OPTUM®

Key Risk
a Berkley Company

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit www.tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM® Key Risk a Berkley Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Key Risk
CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	KRSKFF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-109-KRSKFF

North Carolina Industrial Commission

IC File #_____

Emp. Code #_____

Carrier Code #_____

Employer FEIN_____

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

NOTICE OF ACCIDENT TO EMPLOYER AND CLAIM OF EMPLOYEE, REPRESENTATIVE, OR DEPENDENT (G.S. §§97-22 THROUGH 24)

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employee's Name	Goodwill Ind NW NC Inc. (336) 724-3621 (Employer's Name / Telephone Number)
Address	PO Box 4299 Winston Salem NC 27115 (Employer's Address / City / State / Zip)
City State Zip	Key Risk 992/01062 (Insurance Carrier / Policy Number)
( ) - Home Telephone	PO Box 49129 Greensboro NC 27419 (Carrier's Address / City / State / Zip)
- - Social Security Number ☐ M ☐ F Sex / / Date of Birth	(866) 539-7475 (336) 605-7500 (Carrier's Telephone Number / Carrier's Fax Number)

EMPLOYEE – This form must be filed with the Industrial Commission within two years of the date of injury or occupational disease or your claim may be barred. Notice shall be given to the employer immediately after the accident or as soon as practicable and within 30 days. (This form should also be used for occupational disease claims; however, for asbestosis, silicosis and byssinosis, Form 18B is to be used.)

Notice is hereby given, as required by law, that the above-named employee sustained an injury or contracted an occupational disease, described as follows: _____ (Time of Injury) on ___/___/___ (Date (required)) at _____ (City and County). Describe the injury or occupational disease, including the specific body part involved (e.g., right hand, left hand) _____

Describe how the injury or occupational disease occurred: _____

Occupation when injured: _____ Nature of employer's business: _____

Number of days out of work due to injury:

Medical treatment received? ☐ Yes ☐ No

Weekly wage: $_____ Number of hours worked per day: _____ Days worked per week: _____

NOTE: If employee is unable to sign this form, another may sign for him. This form should be typed or printed by hand in black ink, if possible. Employee should retain one signed copy of this notice, mail one signed copy to the Industrial Commission at the address below, and provide one signed copy to employer.

_____ ( ) - _____

Signature of (Check One) ☐ Employee, ☐ Attorney, ☐ Representative, or ☐ Dependent — Telephone Number

_____ ___/___/___

Address City State Zip — Date Completed

EMPLOYER: This notice is being sent to you in compliance with requirements of the North Carolina Workers' Compensation Act, in order that the medical services prescribed by the Act may be obtained; and, if disability extends beyond 7 days duration, or if death ensues, compensation may be paid according to law.

FORM 18
8/1/08
PAGE 1 OF 1

FOR IC USE ONLY
RESEARCHER: _____
CC: _____
EC: _____
DATA ENTRY: _____

FORM 18

MAIL TO:

NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

GENERAL INFORMATION ON THE FORM 18

1. What does a Form 18 do?

A Form 18 establishes a legal claim of injury on your behalf if filed within two years of the date of injury or occupational disease, and gives the required written notice to the employer if a copy is submitted to the employer within 30 days of the injury. The employer is required by law to file a Form 19 if the employee misses more than one day of work due to the injury or if the medical bills exceed $2,000.00. However, the employer's filing of a Form 19 does not satisfy the employee's obligation to file a claim. In order to ensure the employee's rights are protected, the employee must file a Form 18 even though the employer may be paying compensation or the Industrial Commission may have opened a file for the injury.

2. To whom should the Form 18 be sent?

The original Form 18 should be submitted to the Industrial Commission. The injured worker should keep one copy for his or her records and one copy should be submitted to the employer at the time of the injury.

3. What numbers do I write in the upper right corner?

You do not need to fill in the spaces on the upper right corner of the Form 18. If you know that your employer has already filed a report of injury, (Form 19) and you know what your I.C. (Industrial Commission), File Number is, you may write the number in the "I.C. File No." space. If you do not already have an I.C. File Number, the Industrial Commission will assign one upon receipt of the Form 18. The other three spaces, "Emp. Code No.," "Carrier Code No.," and "Employer FEIN" are for internal use only.

4. What if I do not know who my employer's insurance carrier is?

If you do not know who the employer's insurance carrier is you may either ask your employer for the information, call the Industrial Commission's Claims Administration Section at (800) 688-8349 then press "1" after the prompt, or simply leave the line blank.

5. When listing the number of days out of work, do I count partial days?

Yes, you include partial as well as whole calendar days not worked. However, the days do not need to be consecutive.

6. What happens after I file the Form 18?

The Industrial Commission will mail an acknowledgement letter to you after your Form 18 is processed. Processing time varies according to current workload. The Industrial Commission will mail a copy of the acknowledgement letter to the employer or its workers' compensation insurance carrier asking them to contact you and inform you if compensation will be paid to you voluntarily.