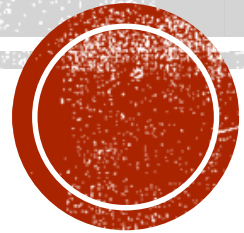
WORKER'S COMPENSATION



Review of Process and Procedure

IN THE UNFORTUNATE EVENT OF AN ACCIDENT OR INJURY WHILE AT WORK, THE FOLLOWING INFORMATION IS PROVIDED TO AID IN COMPLETING A 'FIRST REPORT OF INJURY' AND/OR THE STEPS TO TAKE IN THE EVENT YOU NEED TO SEEK MEDICAL TREATMENT.

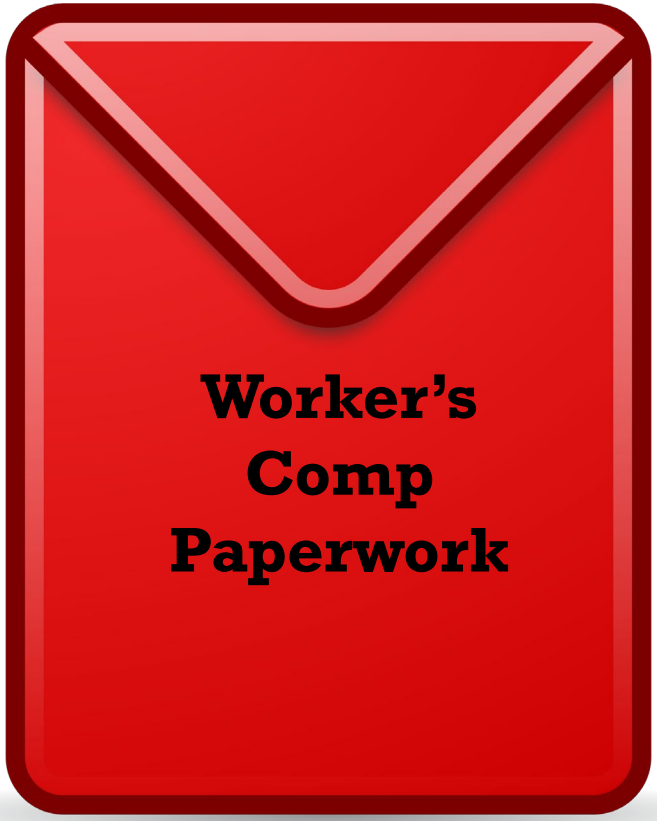
REPORTING OPTIONS

Medcor

Worksite Injury Assessment Service

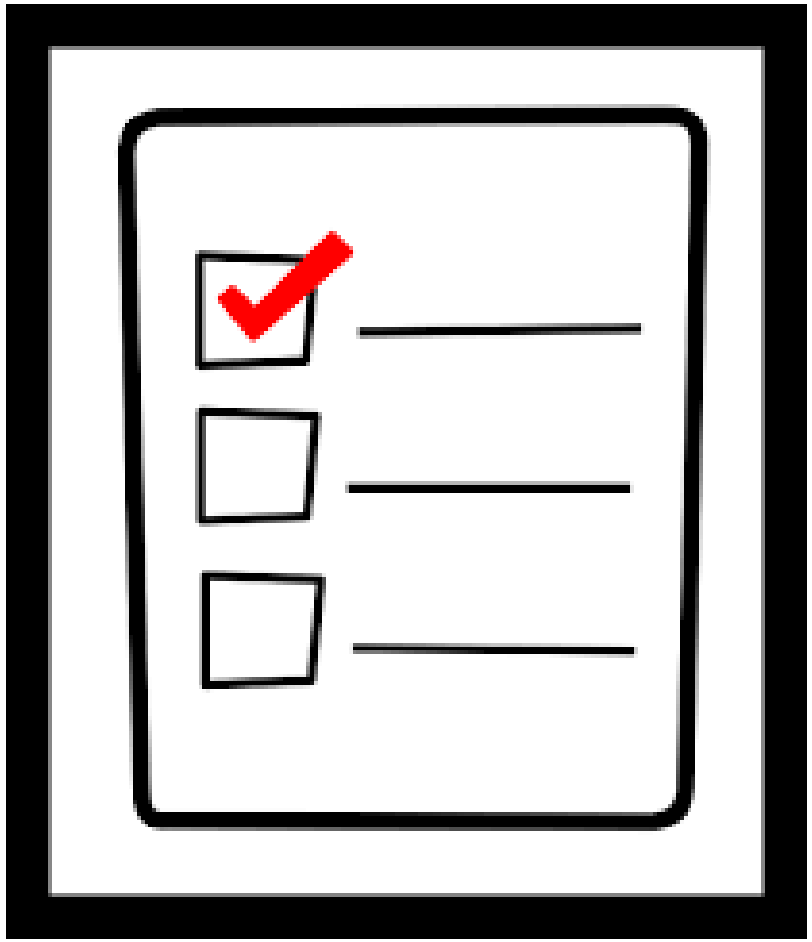
RAS

Paperwork (found in main/nurse's office)



RED REPORTING ENVELOPES

- Complete with any injury, big or small
- Available in each building:
  - Main Office, or
  - Nurse's Office
- Instructions on front of envelope
  - Employee
  - Supervisor
- Return all forms in the red envelope to Benefits Specialist as soon as possible



RISK ADMINISTRATION SERVICES, INC.

EMPLOYEE INJURY REPORT

Claim No.:

INJURED WORKER INFORMATION

Last Name:	First Name:	MI:	Date of Birth:	SSN:

Address:	City:	State:	Zip:

Marital Status: ☐ Married ☐ Unmarried	Gender: ☐ Male ☐ Female	Dependents:	Phone:	Email:

EMPLOYMENT INFORMATION

Employer:	Employer Address:	Yrs employed:

At the time of injury were you employed anywhere else? **(If yes please fill out the following):**

Employer Name: Address: Duties:

Name and address of your former employers:	Have you ever filed a Workers' Compensation claim? ☐ Yes ☐ No When: Employer:

INJURY INFORMATION

Date of Injury:	Time of Injury: ☐ AM ☐ PM	Date you reported injury:	Name/title of person you reported to:

Describe how and what happened to cause this injury:	Where were you when injury occurred?

Name all injuries from this accident:

Have you ever suffered any injuries either work or non-work related before? ☐ Yes ☐ No **(If yes please explain):**

Are you working? ☐ Yes ☐ No	Did you miss work? ☐ Yes ☐ No	Were you paid for any part of time lost? ☐ Yes ☐ No	Date(s) of lost time:

Witnesses:	**TRUCKING ONLY:** Where did your Employer administer your Qualification Tests? City/State

Was your injury the result of someone else's negligence? ☐ Yes ☐ No **(If yes, please fill out the following):**

Name: Address: Phone:

Insurance Co.: Policy or Claim No.:

TREATMENT INFORMATION

Date of first medical treatment:	Are you still under a Dr's care? ☐ Yes ☐ No	Date of most recent treatment?	Are you covered by your spouse's health insurance? ☐ Yes ☐ No

Name and Addresses of all doctors and hospitals treating you:

Have you had previous problems or treatments to this body area(s) ☐ Yes ☐ No **(If yes, please describe and include dates experienced):**	Please list name/address of Group Health Ins:

Employee Signature:	Date:

CORPORATE OFFICE IN SIOUX FALLS, SD
OFFICES IN EAGAN, MN · OMAHA, NE · LAS VEGAS, NV

MAIL: PO Box 89310, Sioux Falls, SD 57109-9310
P. 800.732.1486 F. 877.884.6573
RASCompanies.com

Witness Reporting Form

SCHOOL DISTRICT OF HOLMEN

Injured Employee			
Date of Injury:		Time of Injury:	
Witness Name:		Witness Phone:	( ) -

What is your relationship to the injured person?	
Did you actually witness the incident?	☐ Yes ☐ No
If no, what time did you arrive at the scene?	
What did you see when you arrived?	

If you witnessed the incident, please describe what you saw happen:
In your opinion, what was the cause of the incident?
Do you know of any other people who may have witnessed this incident? If so, please state their names and contact information.

Witness Signature:	
Date:	

RISK ADMINISTRATION SERVICES, INC.

YOUR WORK COMP INFORMATION

This document acts as your Identification Card for your workers' compensation claim. It is important to present this document upon arrival to any medical provider that is treating you for your work-related illness or injury. If you have any questions, please contact your employer or RAS.

This document was created on _____ for _____ only and does not certify compensability or guarantee coverage.
Date — Claim Number

CLAIM INFORMATION

Claim Number:
Carrier:
Jurisdiction:
Patient's Name:
Date of Injury:

PHARMACY INFORMATION

RxBIN:	610729
RxPCN:	ALIUS
Group #:	ALHFF1320216999
Member ID:	ALIUSyymmdd1234 (DOB and last 4 digits of SSN)
Person Code:	01

To locate additional pharmacies or to get an authorization for your medication, please contact 800.547.3330 or visit the website at https://rascompanies.com/resources/

The pharmacy benefit card is only to be used for medications prescribed for your work-related injury. In using the card, you acknowledge and accept financial responsibility for any prescriptions billed under this card that are later found to be unrelated to your injury.
Generics should always be considered as the first line agents for prescribing

PROVIDER INFORMATION

Patient is seeking treatment under Workers' Compensation. Please include claim number and insurance plan/group on each bill for this injury and submit for payment as shown.

ELECTRONIC BILL SUBMISSION:
Payor ID: CB293
Clearinghouse: WorkCompEDI
Contact WorkCompEDI to setup electronic billing.
nassco@workcompedi.com
P. 800.297.6909

PAPER BILL SUBMISSION:
RAS
PO Box 89310
Sioux Falls, SD 57109-9310
Contact RAS for submission or billing questions.
P. 877.585.1117
F. 877.884.6573

Modified Duty is available. Please provide physical capabilities for injured employee and fax to RAS at 877.884.6573.

Visit https://rascompanies.com/resources/ to locate additional medical providers.

SERVICES INFORMATION

The following services must be pre-authorized by RAS. Please contact RAS at 800.732.1486 for any of the following procedures:

- Non-emergency hospitalizations, surgeries, outpatient surgery and transfers
- Physician Referral for specialized care or treatment
- Chiropractic treatment
- Physical Therapy
- Work hardening or Work conditioning programs
- Home Health Care
- Imaging/Diagnostic Studies (CT, MRI, bone scan, myelogram, discogram, EMG)
- Facet, Trigger Point or Epidural Steroid Injections
- Bone Growth Stimulators
- Durable Medical Equipment (DME)
- Request for unusual procedures
- Second Surgical Opinions

Please utilize the vendors below if onsite services are unavailable.

Durable Medical Equipment
PRN Solutions
E. ras@prn4hme.com | P. 800.776.5192 | www.prn4hme.com

Diagnostic Imaging (MRI, CT, EMG)
Absolute Solutions
P. 800.321.5040 | www.absolutedx.com

Home Health
PRN Solutions
E. ras@prn4hme.com | P. 800.776.5192 | www.prn4hme.com

First Fill Instructions for RAS

Dear Injured Claimant,

Alius Health is a business partner of RAS and has been selected to administer your injury prescription drug plan. Attached is your temporary prescription card allowing up to a 10-day supply of medication. Once your claim has been accepted by RAS, a replacement prescription card will be sent to you if you require ongoing treatment. The new card will allow monthly medications related to your injury.

Our extensive pharmacy network includes those below. Simply present this letter along with your prescription(s) to a participating pharmacy. To verify if your preferred pharmacy is in the network, you can use our pharmacy locator on www.Aliushealth.com or call 740-661-4463. Our office hours are Monday through Friday 9am – 7pm Eastern Standard Time.

Name: _____

Member ID: ALIUS

Member ID *is DOB (YYYYMMDD) and last 4 digits of SSN*
Example: **ALIUS194401011234**

Person Code: 01
RxGroup #: ALHFF1320216999
RxBIN/IIN: 610729
RxPCN: ALIUS

ATTENTION PHARMACISTS: Please process prescriptions through **Script Care**. For questions, please call Alius Health 740-661-4463

ATTENTION INJURED CLAIMANT: The use of this prescription card is restricted to your allowed injury' condition only. Possession of this card does not guarantee benefits.

Albertsons	Discount Drug Mart	Good Neighbor Pharmacy	Long's Drug	Sam's Club
BI-LO	Drug Emporium	H E B Drug stores	Medicine Shoppe	Shopko
Bartell Drugs	Family Pharmacy	Health mart	Meijer	Shoprite
Brooks Pharmacy	Fred's	Hy-Vee	Publix	Supervalu
Costco	Fruth Pharmacy	Kroger	Rite Aid	Walgreens
CVS	Giant Eagle Pharmacy	Lewis Drug	Safeway	Walmart

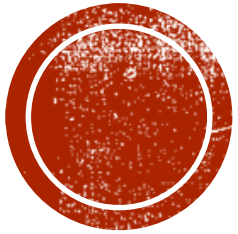
Estimado Trabajador,

Alius Health es socio de RAS ya ha sido seleccionado para administrar su plan de medicamentos recetados para su lesiones. Aquí esta su tarjeta de prescripción temporal que permite hasta 10 días de medicamento. Una vez que su reclamación ha sido aceptada por RAS, se le enviara una tarjeta de reemplazo para requerir tratamiento continuo. La tarjeta nueva le va a permitir medicamentos mensualmente relacionados a su lesion.

Nuestra extensa red de farmacias include las siguientes. Simplemente present esta carta junto con su recetas a una farmacia participantes. Para verificar si su farmacia preferida esta en nuestra red de farmacias puede utilizar nuestro localizador de farmacia en www.Aliushealth.com o llamar 740-661-4463. Nuestra horas de operación son de Lunes a Viernes de 9:00am-7:00pm tiempo de oeste.

SEEKING MEDICAL TREATMENT

- Inform your Supervisor immediately if your injury status changes and/or you need to seek medical treatment
- You will need to clock out of Skyward using available leave time
  - Use reason: Workers Compensation



IF THERE IS NO INITIAL MEDICAL TREATMENT, BUT THE INJURY OR CONDITION WORSENS, PLEASE NOTIFY YOUR SUPERVISOR AND/OR THE BENEFITS SPECIALIST AND SEEK TREATMENT. YOU MAY ACCESS CARE AT THE PROVIDER OF YOUR CHOICE.

OCCUPATIONAL HEALTH SERVICES AT BOTH GUNDERSEN AND MAYO CAN PROVIDE SERVICES TO ASSIST IN RETURNING TO YOUR REGULAR DUTIES AS QUICKLY AS POSSIBLE.

Gundersen Health System – Occupational Health Services
(608) 775-6345

Mayo Clinic Health System – Occupational Health Services
(608) 392-9769

AFTER AN INJURY

- If the injury was reported as "Notice Only", nothing further needs to be done unless the situation changes
- If medical treatment was sought:
  - Request a Return to Work form from the treating Physician or healthcare provider
  - Provide the Return to Work form to the Benefits Specialist as soon as possible
- If restrictions were received:
  - Benefits Specialist will work with Supervisor to review if accommodations can be made

Provider Information

RAS - RISK ADMINISTRATION SERVICES, INC.
P.O. BOX 89310
SIOUX FALLS, SD 57109-9310
(800)-732-1486 EXT 1

FIRSTREPORTS@RASCOMPANIES.COM

RAS
RISK ADMINISTRATION SERVICES, INC.

Contact Information

BENEFITS SPECIALIST – X1305

KRYSTAL MATT, DIRECTOR OF BUSINESS SERVICES – X1302

Additional information relating to Worker's Compensation can be found on the District website under Departments > Business Services > Worker's Compensation or by clicking this link: https://www.holmen.k12.wi.us/departments/workers-compensation.cfm