# NEBRASKA

## CLAIMS KIT

Thank you for choosing RAS for all your workers' compensation needs. Enclosed you will find documentation necessary for the processing and administration in the event of a workers' compensation claim.

**WORKERS' COMPENSATION.**
It's what we do. It's who we are.

**THREE EASY WAYS** to return your completed forms:

**Mail.** PO Box 89310, Sioux Falls, SD 57109-9310
**Online.** RASCompanies.com
**Email.** firstreports@RASCompanies.com

## INCLUDED IN THIS PACKET

- ✓ Injury Reporting Options
- ✓ First Report of Injury **NWCC Form 1**
- ✓ First Fill Instructions for RAS
- ✓ Medical Authorization Form
- ✓ Employee Injury Report
- ✓ Supervisor's Report of Injury
- ✓ Return to Work Form
- ✓ Information Sheet - **Choosing a Doctor for a Work-Related Injury – Rule 50** (EN & SP)
- ✓ Employee's Choice or Change of Doctor Form **NWCC Form 50** (EN & SP)

# Injury Reporting

## CALL
800.732.1486 ext. 1

## EMAIL
Firstreports@RASCompanies.com

## FAX
877.884.6573

## ONLINE
Reporting an Injury online may be completed once your account has been set up. For questions getting an online account or assistance reporting claims online, please contact Policy Services at 800.732.1486 ext. **5556**.

- Go to www.RASCompanies.com
- Click on “For Employers”
- Go to “Click Here to Report a Claim”
- Log in with your user id and password
- Select First Report
- Select New First Report
- Follow instructions to complete the First Report of Injury
- Submit the report

Please report all claims within **24 hours** of the employer receiving notification.

## Nebraska Workers' Compensation Court

# First Report of Alleged Occupational Injury or Illness

NWCC Form 1
Revised 12/2011

### Employer

Employer FEIN ______ SIC Code ______ Report Purpose ______ OSHA Log Case # ______

Employer Name(s) ______

Address ______

______

City ______

State ______ Zip Code ______ Phone ______

Insured Name *(If different from employer name)*

Insured Address *(If different)*

Location ______

### Insurance Carrier

Carrier FEIN ______

Name ______

Address ______

______

City ______

State ______ Zip Code ______ Phone ______

Policy Number ______

Policy Period: From ______ To ______

Insurance Carrier/Self-Insured Code # ______

Administrator FEIN ______

Claim Administrator *(Name, address & phone number)*

Self Insured ☐ *Check if Appropriate*

Claim Administrator Claim # ______

Jurisdiction Claim # ______

Insured Report # ______ Jurisdiction ______

### Employee

Name *(Last, First, Middle)* ______

Address ______

______

City ______

State ______ Zip Code ______ Phone ______

| Date of Birth | Social Security Number | Date Hired |
|---|---|---|
| | | |

Full Pay for DOI Yes ☐ No ☐
Salary Continued Yes ☐ No ☐

Number of Days Worked Per Week ______

Sex Male ☐ Female ☐

Number of Dependents ______

Occupational Job Title

Marital Status: Married ☐ Separated ☐ Unmarried ☐ Unknown ☐

Wage $ ______ Hourly ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐

Occupational Code ______

NCCI Class Code ______

Date Employee Began Work-Related Duties ______

Employment Status FT ☐ PT ☐ Other ☐

### Occurrence/Treatment

| Date of Injury/Illness | Time Employee Began Work AM ☐ PM ☐ | Time of Occurrence AM ☐ PM ☐ (Cannot be determined ☐) | Last Work Date |
|---|---|---|---|
| | | | |

Where Did Injury/Illness Occur?
County ______ State ______ Zip ______

Did Injury/Illness Occur On Employer's Premises? Yes ☐ No ☐

| Date Employer Notified | Date Disability Began | Date Returned to Work | If Fatal, Give Date of Death |
|---|---|---|---|
| | | | |

| | |
|---|---|
| Type of Injury/Illness ***(Briefly describe the nature of the injury or illness; e.g. lacerations to forearm)*** | Nature of Injury Code |
| Part of Body Affected ***(Indicate the part of the body affected by the injury/illness; e.g. right forearm, lowerback; and how it was affected)*** | Part of Body Code |
| How Injury/Illness Occurred ***(Describe activity and tools, materials, equipment the employee was using; how injury occurred)*** | Cause of Injury Code |

Initial Treatment:
- *No medical treatment* ☐
- *First aid by employer* ☐
- *Minor clinic/hospital* ☐
- *Emergency Room* ☐
- *Hospitalized overnight* ☐
- *Hospitalized > 24 hours* ☐
- *Future major medical/lost time* ☐

*Name of physician or other health care provider:*

| Date Administrator Notified | Form Preparer's Name, Title and Phone | Date Prepared |
|---|---|---|
| | | |

# General Instructions

***Underlined items are mandatory fields. A first report of injury or illness submitted without this information will be returned unfiled.***

### *Employer:*

- Employer FEIN — the employer/insured's Federal Employer's Identification Number.
- SIC Code — Standard Identification Classification code which represents the nature of the employer's business.
- Report Purpose — defines the specific purpose of the transaction (examples: original = 00; cancel = 01; change = 02; denial = 04; correction = CO).
- OSHA Log Case # — the Log Case number required for reporting to OSHA.
- Employer Name — include all business names/doing business as *(dba).*
- Address (including city,state, and zip code) — the address of the employer's actual location where the employee was employed at the time of the injury.
- Phone — phone number at the employer's facility.
- Insured Name (*if different from employer*) — the named insured on the policy or the financially responsible self–insured employer.
- Insured Address (*if different from employer*) — mailing address of the insured.
- Location — a code defined by the insured/employer which is used to identify the employer's location.

### *Insurance Carrier:*

- Carrier FEIN — carrier's Federal Employer's Identification Number.
- Administrator FEIN — administrator's Federal Employer's Identification Number.
- Name — the workers' compensation insurer, approved self insured, or intergovernmental risk management pool.
- Address — address, city, state and zip code of insurer.
- Phone — phone number of insurer.
- Claim Administrator (name, address, & phone) — enter the name, address and phone number of the carrier, third party administrator, risk management pool, or self-insurer responsible for administering the claims, if different from carrier information.
- Policy # — the number assigned to the contract/policy for that employer.
- Policy Period — the effective and expiration dates of the contract/policy.
- Insurance Carrier/Self Insured Code # — for insurance carriers, the number assigned by the Nat'l Assn. of Insurance Commissioners. For self-insured employers, the code number assigned by the court.
- Self Insured — check if appropriate.
- Claim Administrator Claim # — identifies a specific claim within a claim administrator's claims processing system.
- Jurisdiction Claim # — number assigned by the court when the initial First Report is accepted.
- Insured Report # — a number used by the insured to identify a specific claim.
- Jurisdiction — the governing body or territory whose statutes apply (NE).

### *Employee:*

- Name — give full name as shown on payroll (avoid initials if possible).
- Address — address, city, state and zip code of employee.
- Social Security Number. The social security number must be provided. This is mandatory pursuant to Neb.Rev.Stat. §48-144, Rule 29 of the Workers' Compensation Court Rules of Procedure, and Section 7(a)(2)(B) of the Privacy Act of 1974. The social security number is used by the Nebraska Workers' Compensation Court for purposes of verifying the identity of the employee and administering the Nebraska Workers' Compensation Act. It is a unique identifier and is needed because of the number of persons who have similar names and birth dates, and whose identities can only be distinguished by social security number. The social security number may also be shared with claims handling entities for purposes of processing a claim for workers' compensation benefits and verifying the identity of the claimant.
- Date of Birth — the date the injured worker was born.
- Date Hired — the date the injured worker began his/her employment with the employer.
- Full Pay for DOI (date of injury) — check one.
- Salary Continued — check one.
- Number of Days Worked Per Week — the number of the employee's regularly scheduled work days per week.
- Sex — check one.
- Number of Dependents — the number of dependents as defined by the Nebraska Workers' Compensation Act.
- Marital Status — check one.
- Wage — check one and state wage.
- Occupational Job Title — the primary occupation of the claimant at the time of the accident.
- Occupational Code — Standard Occupational Classification code used to identify the primary occupation of the employee at the time of the accident.
- NCCI Code — The identifying number for an occupational classification.
- Date Employee Began Work-Related Duties — date pertaining to employee's present occupation.
- Employment Status — check one.

### *Occurrence/Treatment:*

- Date of Injury/Illness — date on which the accident occurred (*only one date of injury per form*).
- Time Employee Began Work — time employee began work for that date.
- Time of Occurrence — time of day the injury occurred.
- Last Work Date — the last paid work day prior to the initial date of disability.
- Where Did Injury/Illness Occur — complete county, state, and zip code.
- Did Injury/Illness Occur On Employer's Premises — check one.
- Date Employer Notified — the date that the injury was reported to a representative of the employer.
- Date Disability Began — if not disabled answer none and skip questions.
- Date Returned to Work — if injured has returned to work, complete this question.
- If Fatal, Give Date of Death, (date employee died as a result of the work-related injury.)
- Type of Injury/Illness — describe the nature of injury.
- Nature of Injury Code — the code which corresponds to the nature of the injury sustained by the employee.
- Part of Body Affected — the part of the body to which the employee sustained injury.
- Part of Body Code — the code which corresponds to the Part of the body to which the employee sustained injury.
- How Injury/Illness Occurred — a free-form description of how the accident occurred and the resulting injuries.
- Cause of Injury Code — the code that corresponds to the cause of injury.
- Initial Treatment — check one.
- Name of physician or other health care provider — provide name of physician or other health care provider that treated employee for injury.
- Date Administrator Notified — the date the claim administrator who is processing the claim received notice of the loss or occurrence.
- Form Preparer's Name, Title and Phone.

# 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*: 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 | Valu-Rite |
| 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.

RISK ADMINISTRATION SERVICES, INC.

Injured Worker:

Claim No.:

Date of Birth:

# AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my medical information (also known as protected health information) as described below.

**Facility Name:** ______________________________________________________________________________
Enter the name of doctor's office, hospital, or other healthcare facility you are authorizing to send us your medical information.
**Use separate form for each if more than one.**

I, ________________________, authorize all persons or entities that provided medical treatment to me to disclose the following medical information in your possession to RAS, its employees, agents, subcontractors and authorized representatives.

Please provide RAS with any and all information in your possession concerning my physical condition, past, present and future, including but not limited to, healthcare history, diagnosis, condition, treatment or evaluation and other medical information so that they may use it or disclose it to evaluate, administer and resolve my claim related to injuries I received on ________________. I understand that the medical information that is disclosed may include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. *

I, ____________________________, authorize the State to release to Insurer/RAS and/or its representatives a complete copy of all records pertaining to past or present Workers' Compensation claims.

I hereby authorize Insurer/RAS to reproduce, distribute or use any or all protected health information from any past or present Workers' Compensation claims that I may have had with Insurer/RAS. I further authorize Insurer/RAS to retain any or all protected health information it may receive related to the injury I received on __________________.

This authorization shall be in force and effective until my claim related to the injury, I received on _______________ is resolved, at which time this authorization to use or disclose this protected health information expires. I understand that I may revoke this authorization by notifying [**RAS Inc, PO Box 89310, Sioux Falls, SD 57109**] in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by RAS or the Releasing Party in Reliance on it before I revoked it.

As the person signing this Authorization for Release of Protected Health Information, I understand that I am giving permission to RAS to obtain and use protected health information. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

A copy of this authorization may be accepted with the same authority as the original.

I understand this authorization is voluntary. As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the **health care entity** may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. While I do not need to sign this authorization to ensure **healthcare treatment**, I understand that failure to do so may have impact on my entitlement to payment of Workers' Compensation benefits.

| | |
|---|---|
| Print Name of Patient or Personal Representative | Description of Personal Representative's Authority |
| X<br>**Signature of Patient or Personal Representative** | Date |

*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.



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# 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<br>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:**<br>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<br>**(If yes, please describe and include dates experienced):** | Please list name/address of Group Health Ins: |
|---|---|

| **Employee Signature:** | **Date:** |
|---|---|



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# SUPERVISOR'S REPORT OF ACCIDENT

The primary purpose of the SRA is to investigate the accident. It is also used to report the accident to the central office where the First Report of Injury is then completed by administrative personnel. The SRA should be filled out as soon as possible after the accident.

Every accident should be investigated, and the causes corrected so that more accidents will not occur. Do not overlook the so-called "unimportant' cases, because, except for "chance" they could also have been serious. It is only by thorough investigation that many of the real causes can be determined and corrected. *This report should not be completed by the injured employee*.

| **INJURED WORKER** | | | |
|---|---|---|---|
| Name of Employee: | Company: | Department: | Date of Accident: |
| Time: | Did Employee lose time from work? ☐ **Yes** ☐ **No** | Hours lost on date of accident: | Has employee returned to work: ☐ **Yes** ☐ **No** |
| Job Title: | Service with the Company: | Years in present job: | |

| **SAFETY QUESTIONS** | |
|---|---|
| **1.** | Was injured person properly instructed in safe and efficient methods? ☐ **Yes** ☐ **No**<br>*Supervisors should instruct their employees on how to do the job efficiently and safely.* |
| **2.** | Did injured person violate any instructions? ☐ **Yes** ☐ **No**<br>*What was the violation?* |
| **3.** | Was necessary protective equipment worn? (if applicable) ☐ **Yes** ☐ **No**<br>*The supervisor should have told the employee what personal protective equipment is necessary to do the job. Did the employee wear the personal protective equipment when this job was being done?* |
| **4.** | Did poor housekeeping contribute to injury? ☐ **Yes** ☐ **No**<br>*Was the work area clean and well organized? i.e., scraps on the floor, blocked aisles, wet floor, spilled food, etc.* |
| **5.** | Did horseplay cause the injury? ☐ **Yes** ☐ **No**<br>*Was there inadequate supervision? Did horseplay or practical jokes contribute to the accident?* |
| **6.** | Was it caused by something that needed repairs? ☐ **Yes** ☐ **No**<br>*i.e., broken ladder, bad electric cord on drill, etc.* |
| **7.** | Should a guard be provided? ☐ **Yes** ☐ **No**<br>*i.e., guard around the belts and pulleys, railing properly in place, guard on saw, etc.* |
| **8.** | Did any bodily defect contribute to injury? ☐ **Yes** ☐ **No**<br>*i.e., poor vision, previous back injury, etc.* |
| **9.** | Was it caused by an unsafe act? ☐ **Yes** ☐ **No**<br>*Most injuries are caused in part by unsafe acts. An Unsafe Act is something that the injured person or another person did, that he or she should not have done, which led to the accident. Below is a list of the most common unsafe acts and contributing factors:*<br>**1.** Operating without authority<br>**2.** Failure to warn or secure<br>**3.** Operating at unsafe speed<br>**4.** Making safety devices in-operative<br>**5.** Using equipment, tools, materials or vehicles unsafely<br>**6.** Using defective equipment, materials, tools or vehicles<br>**7.** Failure to use personal protective equipment<br>**8.** Failure to use equipment provided (except personal protective equipment)<br>**9.** Unsafe loading, placing and mixing<br>**10.** Unsafe lifting and carrying (including insecure grip)<br>**11.** Taking an unsafe position<br>**12.** Adjusting, clearing jams, cleaning machinery in motion<br>**13.** Distracting, teasing<br>**14.** Poor housekeeping practices<br>**15.** Disregard of instructions<br>**16.** Lack of knowledge or skill<br>**17.** Action of other than injured<br>**18.** Others… |
| **10.** | Did injured report the injury to you, the supervisor, immediately? ☐ **Yes** ☐ **No** |

Continued on next page

## ACCIDENT INFORMATION

**Accident** – Describe what injured was doing at time of accident, what happened, who was involved, nature of injury, part of body affected. *Example: John was drilling a hole in the ceiling and chips of plaster fell into his eye.*

**Witnesses' Names**:

**Unsafe Acts** – What did the employee or another person do incorrectly?
*Refer to Question 9 above and examples of Unsafe Acts. Example: John was not wearing proper personal protective equipment.*

**UNSAFE CONDITIONS**

1. Defective tools, equipment, substances
2. Unsafe design or construction
3. Hazardous arrangement
4. Improper illumination
5. Improper ventilation
6. Improper dress
7. Poor housekeeping
8. Congested area
9. Other

**Actions Taken** – What did you do to correct the conditions which caused this accident?
*Example – John has been re-instructed to wear proper personal protective equipment such as goggles or face shield when drilling overhead.*

**Remedies** – What should your organization do to prevent other injuries like this?
*Example – Standard safety policy should be adopted that requires use of personal protective equipment. This policy should be strictly enforced by the supervisors.*

## MEDICAL CARE

Did employee go to doctor or hospital? ☐ **Yes** ☐ **No** **If yes please complete the following below**

| Date of Initial Visit: | Name of Doctor or Hospital: | Address: | Phone: |
|---|---|---|---|
| | | | |

As a supervisor, do you feel that this injury should be covered under Workers' Compensation? ☐ **Yes** ☐ **No**

| Report Submitted by: **(Name and Title)** | Date: |
|---|---|
| | |



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RISK ADMINISTRATION SERVICES, INC.

# RETURN TO WORK REPORT

TO BE COMPLETED BY **ATTENDING PHYSICIAN** AND RETURNED TO EMPLOYER IMMEDIATELY FOLLOWING EACH APPOINTMENT.

## Patient Information:

| **Last Name:** | | **First Name:** | **MI:** |
|---|---|---|---|
| **Date of Injury:** | **Date of Treatment:** | **Brief Explanation of Diagnosis/Condition:** | |

## Limitations:

**Based on the above description of the patient's current medical problem, I am recommending the following:**

☐ Patient may return to work with no limitations on: ________________________________

☐ Patient may not return to work with limitations listed below.

| | | |
|---|---|---|
| ☐ | **SEDENTARY WORK**<br>Lifting up to 10 pounds occasionally and frequently lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. | In an ____ hour work day, patient may:<br>**Stand:**<br>☐ None ☐ 1-4 Hours<br>☐ 4-6 hours ☐ 6-8 hours |
| ☐ | **LIGHT WORK**<br>Lifting up to **20 lbs** occasionally with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pull of arm and/or leg controls. | **Sit:**<br>☐ 1-3 hours ☐ 3-5 hours ☐ 5-8 hours<br>**Drive:**<br>☐ 1-3 hours ☐ 3-5 hours<br>☐ 5-8 hours ☐ 8+ hours |
| ☐ | **MEDIUM WORK**<br>Lifting **50 lbs** maximum and frequent lifting or carrying of objects weighing up to 25 lbs. | **Patient may use hand(s) for repetitive:**<br>☐ Single Grasping ☐ Fine Manipulation<br>☐ Pushing/Pulling ☐ Firm Grasping<br>☐ Patient is not to use injured hand |
| ☐ | **LIGHT-HEAVY WORK**<br>Lifting **75 lbs** maximum and frequent lifting or carrying of objects weighting up to 40 lbs. | **Patient is able to:**<br>☐ Bend ☐ Squat ☐ Kneel ☐ Climb stairs<br>☐ Reach above shoulders |
| ☐ | **HEAVY WORK**<br>Lifting **100 lbs** maximum and frequent lifting or carrying of objects weighing up to 50 lbs. | **Patient may use foot/feet for repetitive movement as in operating foot controls.**<br>☐ Yes ☐ No |
| **Condition:**<br>☐ Worse ☐ Discharged ☐ Improved ☐ Resolved ☐ Reach above shoulders | | **No Change in:**<br>☐ Diagnosis ☐ Treatment<br>☐ Work Restriction |

**Other instructions and/or limitations, including prescribed medications:**

| | |
|---|---|
| ☐ **These restrictions are in effect until:** | ☐ **Or until patient is re-evaluated on:** |

☐ **Patient is totally incapacitated at this time and a re-evaluation is scheduled on:**

| **Physician's Signature:** | **Date:** |
|---|---|



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RASCompanies.com

*Nebraska Workers' Compensation Court Information Sheet:*

# Choosing a Doctor for a Work-Related Injury — Rule 50

***Note:*** **The rights to choose and change doctors are governed by statute and rules. This is a simplified explanation of those rights. Please refer to §48-120 and Rules 50 and 56 for further information.**

## *If you are the EMPLOYEE:*

Tell your employer when you have an injury that arises out of and is in the course of your work.

After you report a work injury, your employer may tell you about your right to choose a doctor to treat you for that injury. (Doctor means a person licensed to practice medicine and surgery, osteopathic medicine, chiropractic, podiatry, or dentistry.)

***If your employer does tell you about your right to choose a doctor, you may choose ONLY a doctor who has treated you or a member of your family before your injury.*** (Family member means your spouse, child, parent, stepchild or stepparent.) The doctor must have records of that treatment. If your employer asks, you or your family member must give your employer written permission to verify that treatment.

If you have such a doctor and want that doctor to treat you for your work injury, you need to ***tell your employer the name of the doctor.*** If you don't have such a doctor, do not tell your employer the name of the doctor, or refuse to give permission for your employer to verify treatment, ***your employer can choose the doctor to treat you for your work injury.*** It is best if you give your employer the name of your doctor in writing. Unless it is an emergency, you cannot get any treatment for the work injury until you have given your doctor's name to your employer. If it is an emergency, get the treatment you need, then tell your employer the name of your doctor.

***After being told about your right to choose a doctor there can be no change in the doctor chosen*** unless you and your employer agree to the change or the court orders a change. This is true whether you or your employer chose the doctor in the first place. If you are referred to another doctor for special tests or services, this is not a change in doctor.

***If your employer does not tell you about your right to choose a doctor, you may choose ANY doctor.***

***There are other times when you can choose your doctor.*** These times are: to do major surgery; if your injury involves dismemberment; or, if your claim is denied.

***You may have to pay for services you receive if you do not follow the rules about choosing or changing doctors.***

## *If you are the EMPLOYER:*

***You may wish to choose the doctor*** to treat an employee's work injury. If you want to make the choice, as soon as you can after you know about an injury, you must tell the employee of the right to choose a doctor. The employee must be told of the right to choose a doctor before the employee can be treated by a doctor chosen by you. You must allow the employee a reasonable amount of time to choose the doctor. The court has a form you can use to tell the employee about these rights (Form 50).

***You may choose the doctor if,*** after telling the employee about the right to choose: no doctor has treated the employee or a member of the employee's family before the work injury; or the employee does not select a doctor who has records of such treatment; or you are refused the authorization needed to verify such prior treatment, if you should ask for it.

***After telling the employee about the right to choose there can be no change*** in doctor unless you and the employee agree or the court orders a change. This is true whether you or your employee chose the doctor. If the employee is referred to another doctor for special tests or services, this is not a change in doctor.

Even if you tell the employee about the right to choose and then you get to choose the doctor, ***the employee is free to choose a doctor at other times.*** The employee can choose the doctor: to do major surgery; if the injury involves dismemberment; or if the claim is denied.

If you do not wish to choose the doctor for your employee, you do not need to tell the employee about the right to choose the doctor. ***The employee can then choose ANY doctor to provide treatment for the work injury.***

## *Common questions asked by employees:*

### Can my employer make me see another doctor?

Your employer cannot make you get treatment from another doctor. But, your employer (or their insurance company) can ask you to see another doctor for an examination. This doctor will not start treating you; it will just be an examination. You can refuse to see this doctor only if you have a good reason. If you do not have a good reason, you may not get payments for the time you refuse to be seen. You may be asked to see more than one doctor for other examinations.

### What if I want to change doctors?

***If the doctor has been chosen AFTER your employer told you of your rights, you can't change doctors*** unless your employer agrees or the court orders a change. If you want to change, talk to your employer about the reasons. If your employer agrees, you may change.

### What if my employer wants me to change doctors?

***If the doctor has been chosen AFTER your employer told you of your rights, you can't be made to change your doctor*** unless you agree or unless the court orders you to change.

### What if it is an emergency?

If it is an emergency, see any doctor as soon as you can. The rules don't apply until after the emergency is over. Then, if you need more treatment, the rules apply.

### What if my employer or the insurer has a managed care plan?

You can still choose a doctor. It must be one who has treated you or a family member before your injury. ***Your doctor must agree to the rules of the plan.*** If you don't have a doctor, you may choose among the doctors signed up with the plan.

### If I chose a doctor when my employer told me about my right to choose, can I change my choice?

***You may not change your choice of doctor*** unless your employer agrees to the change or unless the court orders a change.

**What if my employer won't agree to let me change doctors?**

You can ask for Informal Dispute Resolution (IDR) from the court. You must first try to get your employer to agree. If this doesn't work, you or your employer can ask for help through the IDR process. A court staff member will try to help you and your employer agree. If that doesn't work, a motion or petition (lawsuit) can be filed with the court.

**What if my employer doesn't tell me about my rights to choose a doctor?**

***You may choose ANY doctor to treat you.***

**This information sheet has been prepared by the Nebraska Workers' Compensation Court to answer some of the commonly asked questions concerning workers' compensation. Further inquiries should be directed to:**

**Nebraska Workers' Compensation Court**
**P.O. Box 98908**
**Lincoln, NE 68509-8908**

**800-599-5155 or 402-471-6468**

**http://www.wcc.ne.gov/**

**Revised November 1999**

# NOTICE OF EMPLOYEE'S RIGHT TO CHOOSE A DOCTOR

***NOTICE TO EMPLOYER:*** *Give this form to the injured worker as soon as possible* ***AFTER*** *each injury.*

## EMPLOYEE MAY CHOOSE

When you are injured at work, you may have the right to choose a doctor to treat you.

If your employer gives you notice of this right following the accident, your choice of doctor is limited to a doctor who has treated you or an immediate family member before the injury.

- You must choose as soon as possible after your employer gives you this notice.
- If you have such a doctor and want that doctor to treat you for your work injury, you must tell your employer the name of the doctor.
- You can use the *Choice of Doctor Designation Form* below to record the name of the doctor you choose.
- Immediate family members are your spouse, children, parents, stepchildren, and stepparents.
- If your employer asks, you or your family member must give your employer written permission to verify prior treatment.

If it is an emergency, get the treatment you need, then tell your employer the name of your doctor.

You may choose any doctor to perform major surgery or an amputation, if that treatment is recommended.

Once you choose your doctor, you may not change doctors unless your employer agrees or the Nebraska Workers' Compensation Court orders a change. A referral made by the chosen doctor is not a change.

If your claim is denied, you may choose any doctor. You will be responsible for the medical bills unless your employer is later found liable for the claim.

If you choose a doctor outside the community where you live or work, and a doctor is available in a closer community, you will not receive mileage reimbursement.

## EMPLOYER MAY CHOOSE

If you were notified, but do not choose a doctor who treated you or a family member before the accident, YOUR EMPLOYER HAS THE RIGHT TO CHOOSE YOUR DOCTOR.

If you were notified, but you or your family member do not give permission for your employer to verify prior treatment with the doctor you choose, YOUR EMPLOYER HAS THE RIGHT TO CHOOSE YOUR DOCTOR.

### EMPLOYEE CONFIRMATION OF NOTICE

My employer has informed me of the right to choose a doctor.

______________________________
[EMPLOYEE NAME]

______________________________
[EMPLOYEE SIGNATURE]

______________________________
[DATE OF NOTICE]

### EMPLOYER CONFIRMATION OF NOTICE

I have informed my employee of the right to choose a doctor.

______________________________
[EMPLOYER REPRESENTATIVE NAME]

______________________________
[EMPLOYER REPRESENTATIVE SIGNATURE]

______________________________
[DATE OF NOTICE]

## CHOICE OF DOCTOR DESIGNATION FORM

I choose the following doctor to treat me for the work-related injury I had on ________________ [DATE OF INJURY]. I certify that this doctor has treated me or an immediate family member before the work-related injury.

______________________________
[DOCTOR NAME]

______________________________
[EMPLOYEE SIGNATURE]

______________________________
[DOCTOR ADDRESS, IF KNOWN]

______________________________
[DATE]

**OR** (Indicate your reason(s) for not choosing a doctor)

- ☐ I do not have a doctor who has treated me or an immediate family member before this injury.
- ☐ I have received notice of my right to choose a doctor, but I do not wish to choose a doctor who has treated me or an immediate family member.

______________________________
[EMPLOYEE SIGNATURE]

______________________________
[DATE]

*Folleto Informativo de la Corte de Compensación para Trabajadores de Nebraska:*

# Como Seleccionar un Doctor para Lesiones de Trabajo Regla 50

***Nota:*** **Los derechos a seleccionar y a cambiar de doctor están sujetos aestatutos y reglas. Esta es una explicación simplificada de esos derechos. Para información adicional lea los reglamentos 48-120, Reglas 50 y 56.**

## *Si usted es el EMPLEADO:*

Infórmele a su empleador que Ud. tiene una lesión como consecuencia del trabajo y mientras estaba trabajando.

Después que reporte una lesión a consecuencia del trabajo, su empleador le puede hablar acerca de su derecho a escoger un doctor que lo atienda por esa lesión. (Un doctor es una persona licensiada para practicar medicina y operaciones, medicina osteopática, terapista, podiatría y odontología.)

***Si su empleador le explica su derecho a escoger un doctor, usted puede escoger SOLAMENTE un doctor que lo haya atendido a usted o, a un miembro de su familia antes de la lesión o el accidente.*** (Miembros de su familia, se refieren a: su cónyugue, hijo/a, padre/madre, hijastro/a o padrasto/madrastra.) El doctor debe mantener archivos del tratamiento. Si su empleador le pide, usted o el miembro de su familia le debe dar a su empleador autorización por escrito para verificar el tratamiento.

Si usted tiene un doctor y quiere que ese doctor lo/la atienda por la lesión de trabajo, usted necesita ***informarle a su empleador el nombre del doctor.*** Si usted no tiene tal doctor, no le diga a su empleador el nombre del doctor, o se niege a dar autorización por escrito para que su empleador verifique el tratamiento, ***su empleador puede escoger el doctor para atenderlo por su lesión de trabajo.*** Es mejor que usted le dé, el nombre del doctor a su empleador por escrito. A menos que sea una emergencia, a usted no le pueden dar tratamiento por la lesión de trabajo hasta que le haya dado el nombre del doctor a su empleador. Si es una emergencia, reciba el tratamiento que necesite, y después dígale a su empleador el nombre del doctor.

***Después que le expliquen su derecho acerca de escoger un doctor, no pueden haber cambios acerca del doctor escogido*** a menos que usted y su empleador lleguen a un acuerdo acerca del cambio o que la corte ordene un cambio. Este es el caso, ya sea que usted o su empleador escojan el doctor inicialmente. Si a usted lo envían a otro doctor para pruebas o servicios especiales, esto no constituye un cambio de doctor.

***Si su empleador no le dice nada acerca de su derecho a escoger un doctor, usted puede escoger CUALQUIER doctor.***

***Hay otras circunstancias cuando usted puede escoger su doctor.*** Estas circunstancias son: cuando necesita una operación de riesgo; si su lesión involucra amputaciones de alguna parte de su cuerpo; o, si su petición le es negada.

***Usted tendrá que pagar por servicios que reciba si no sigue las reglas acerca de escoger o cambiar de doctor.***

## *Si usted es el EMPLEADOR:*

***Usted puede escoger el doctor*** para atender al empleado por lesiones de trabajo. Si usted quiere hacer la elección lo más pronto que pueda, después que sea informado acerca de la lesión, usted debe decirle al empleado

acerca de su derecho a escoger un doctor. El empleado debe ser informado de su derecho a escoger un doctor, antes que el empleado sea atendido por un doctor escogido por usted. Usted debe darle al empleado una cantidad de tiempo razonable para que escoja un doctor. La corte tiene un formulario que usted puede usar para decirle al empleado acerca de estos derechos (Formulario 50.)

***Usted puede escoger el doctor si,*** después de explicarle al empleado su derecho a escoger: ningún doctor ha atendido al empleado o, a algún miembro de la familia del empleado antes de la lesión de trabajo; o, si el empleado no escoge un doctor quien tenga archivos de tal tratamiento; o, si a usted le niegan la autorización necesaria para verificar dicho tratamiento previo si usted la solicita.

***Después de explicarle al empleado su derecho a escoger, no pueden haber cambios*** de doctor a menos que usted o el empleado lleguen a un acuerdo o, que la corte ordene un cambio. Este es el caso, ya sea que usted o el empleado escoja el doctor. Si es necesario que el empleado sea atendido por otro doctor para pruebas o servicios especiales, esto no constituye un cambio de doctor.

Aún si le explica al empleado su derecho a escoger y después usted escoge el doctor, ***el empleado puede escoger el doctor en algunas ocaciones.*** El empleado puede escoger el doctor: si necesita alguna operación de riesgo; si la lesión involucra la amputación de alguna parte de su cuerpo; o, si la petición es negada.

Si usted no desea escoger el doctor para su empleado, usted no tiene que decirle al empleado acerca de su derecho de escoger el doctor. ***El empleado de esa manera puede escoger CUALQUIER doctor quien lo/la atienda por la lesión de trabajo.***

## *Preguntas comunes de los empleados:*

### ¿Mi empleador puede obligarme a ser atendido por otro doctor?

Su empleador no puede obligarlo a ser atendido por otro doctor. Pero, su empleador (o, su compañía de seguros) le pueden pedir que sea visto por otro doctor para un examen. Este doctor no va a empezar tratamiento, solo será un examen. Usted se puede negar a ser atendido por este doctor solamente si usted tiene una buena razón. Si usted no tiene una buena razón, usted no puede obtener pagos por el tiempo en el cual se niega a ser atendido. A usted le pueden pedir que sea atendido por otros doctores para otras pruebas.

### ¿Qué debo hacer si quiero cambiar de doctor?

***Si el doctor ha sido escogido DESPUÉS que su empleador le explicó su derecho a escoger, usted no puede cambiar de doctor*** a menos, que su empleador esté de acuerdo o, que la corte ordene el cambio. Si usted quiere cambiar, hable con su empleador de sus razones. Si su empleador está de acuerdo, usted puede cambiar.

### ¿Qué debo hacer si mi empleador quiere que cambie de doctor?

***Si el doctor ha sido escogido DESPUÉS que su empleador le explicó sus derechos, no lo pueden obligar a cambiar de doctor,*** a menos, que usted esté de acuerdo o, a menos que la corte le ordene el cambio.

### ¿Qué debo hacer si es una emergencia?

Si es una emergencia, vaya a ver a cualquier doctor lo más pronto posible. Las reglas no empiezan hasta después que la emergencia pase. Después, si usted necesita más tratamiento, entonces las reglas toman efecto.

### ¿Qué debo hacer si mi empleador o mi compañía de seguros tienen un plan de seguros?

Usted puede escoger su doctor de todas maneras. Debe ser un doctor que lo haya atendido a usted o, a algún miembro de su familia antes de la lesión. ***Su doctor debe estar de acuerdo con las reglas del plan.*** Si usted no tiene doctor, usted puede escoger entre los doctores inscritos en el plan.

**Si yo escojo un doctor cuando mi empleador me ha explicado mi derecho a escoger, ¿puedo cambiar mi elección?**

***Usted no puede cambiar su elección de doctor*** a menos que su empleador esté de acuerdo con el cambio, o, que la corte ordene un cambio.

**¿Qué debo hacer si mi empleador no está de acuerdo que yo cambie de doctores?**

Usted puede solicitar de la corte una Disputa Informal de Concuerdo (Informal Dispute Resolution- IDR). Usted primero debe tratar que su empleador esté de acuerdo. Si esto no dá resultado, usted, o su empleador pueden pedir ayuda por medio del proceso IDR. Un miembro del personal de la corte tratará de ayudarlos a usted y a su empleador a llegar a un acuerdo. Si eso no dá resultado, se puede entablar una demanda en la corte.

**¿Qué debo hacer si mi empleador no me explica mi derecho a escoger un doctor?**

***Usted puede escoger CUALQUIER doctor para que lo atienda.***

**Este folleto informativo ha sido preparado por la Corte de Compensación para Trabajadores de Nebraska para responder las preguntas más comunes en relación a la compensación para trabajadores. Preguntas adicionales deben ser dirigidas a:**

**Nebraska Workers' Compensation Court**
**P.O. Box 98908**
**Lincoln, NE 68509-8908**

**800-599-5155 o 402-471-6468**

**http://www.wcc.ne.gov/**

**Revisado Noviembre 1999**

# NOTIFICACIÓN DEL DERECHO DEL EMPLEADO A ELEGIR UN MÉDICO

***NOTIFICACIÓN AL EMPLEADOR:*** *Entréguele este formulario al trabajador lesionado tan pronto como sea posible* ***DESPUÉS*** *de cada lesión.*

## EL EMPLEADO PUEDE ELEGIR

Cuando Ud. sufra una lesión laboral, puede que tenga el derecho a elegir el médico que lo trate.

Si su empleador le notifica de este derecho después del accidente, la elección que tiene Ud. está limitada a un médico que ha tratado o bien a Ud. o a un familiar cercano antes de la lesión.

- Ud. debe de hacer su elección tan pronto como sea posible después de que su empleador le dé esta notificación.
- Si Ud. tiene tal médico y quiere que ese médico le trate su lesión laboral, debe de decirle al empleador el nombre del médico.
- Ud. puede utilizar el *Formulario de Nombramiento de Médico Elegido* a continuación para registrar el médico que Ud. elige.
- Los familiares cercanos incluyen su esposo/a, hijos, padres, hijastros y padrastros.
- Si su empleador se lo pide, Ud. o su familiar debe de entregarle permiso escrito para verificar tratamiento previo.

Si es una emergencia, reciba el tratamiento que necesite, y luego dígale a su empleador el nombre de su médico.

Ud. puede elegir cualquier médico para operarle en una cirugía mayor o amputación si ese tratamiento está recomendado.

Una vez elegido el médico, no se le permite cambiar de médicos a no ser que su empleador esté de acuerdo o si el Tribunal de Compensación de Trabajadores ordene tal cambio. No constituye un cambio de médicos si el médico elegido le deriva a Ud. a otro médico.

Si se le niega el reclamo, Ud. puede elegir cualquier médico. Ud. será responsable por los gastos médicos a no ser que se le responsabilice a su empleador por el reclamo en un momento futuro.

Si Ud. elige un médico fuera de la comunidad en la que vive o trabaja y se encuentra disponible un médico en una comunidad más cercana, Ud. no recibirá reembolso por millaje.

## EL EMPLEADOR PUEDE ELEGIR

Si Ud. fue notificado pero no elige un médico que ha tratado a Ud. o a un familiar antes del accidente, entonces SU EMPLEADOR TIENE EL DERECHO A ELEGIR EL MÉDICO.

Si Ud. fue notificado pero Ud. o su familiar no le da permiso al empleador para que verifiquen tratamiento previo con el médico que Ud. elige, entonces SU EMPLEADOR TIENE EL DERECHO A ELEGIR EL MÉDICO.

### CONFIRMACIÓN DE NOTIFICACIÓN AL EMPLEADO

Mi empleador me ha notificado del derecho a elegir un médico.

______________________________
[NOMBRE DEL EMPLEADO]

______________________________
[FIRMA DEL EMPLEADO]

______________________________
[FECHA DE NOTIFICACIÓN]

### EMPLOYER CONFIRMATION OF NOTICE

Yo le he informado a mi empleado de su derecho a elegir un médico.

______________________________
[NOMBRE DEL REPRESENTANTE DEL EMPLEADOR]

______________________________
[FIRMA DEL REPRESENTANTE DEL EMPLEADOR]

______________________________
[FECHA DE NOTIFICACIÓN]

## FORMULARIO DE NOMBRAMIENTO DE MÉDICO ELEGIDO

Yo elijo que el siguiente médico me trate por la lesión laboral que sufrí el ________________ [FECHA DE LESIÓN]. Doy fe de que este médico ha tratado o bien a mí o a un familiar cercano antes de esta lesión laboral.

______________________________
[NOMBRE DEL MÉDICO]

______________________________
[FIRMA DEL EMPLEADO]

______________________________
[DIRECCIÓN DEL MÉDICO, SI SE SABE]

______________________________
[FECHA]

**O** (Marque la(s) razón(es) por no elegir un médico)

☐ No hay médico que ha tratado o a mí o a un familiar cercano antes de esta lesión.

☐ He recibido notificación de mi derecho a elegir un médico pero no deseo elegir un médico que ha tratado o a mí o a un familiar cercano.

______________________________
[FIRMA DEL EMPLEADO]

______________________________
[FECHA]