Injured Employee Instructions

You should:

1. Review and retain the brochure "Understanding the West Virginia Workers' Compensation Claims Process." This brochure explains your rights under West Virginia workers' compensation law.

2. Complete the top section of the state-required OIC-WC-1 form and give it to the treating physician at your first visit. The treating physician can assist you with completion of the top section if needed. The bottom section of the form must be completed by the treating physician.

3. Request the treating physician to email the completed form to WVcorp at the following address.

WVcorp

1819 Electric Rd. STE C
Roanoke, VA 24018
Fax # 540-345-5330
Email: tech1@riskprograms.com

NOTE: Your workers' compensation claim is not considered submitted until the fully completed form is received by WVcorp; however, you can contact the office for the claim number at 888-822-6772. Please allow 24/48 hours.

4. Present the myMatrixx form to the pharmacy when you pick up the workers' compensation prescription to receive a free14-day supply of the prescription. Many medications can be provided without WVcorp's authorization. myMatrixx will contact WVcorp if pre-approval is required for your 14-day fill.

Understanding the West Virginia Workers' Compensation Claims Process:

Information an Injured Worker Needs to Know

Whom do I contact for information about my claim?

Your workers' compensation claim will be handled by West Virginia Communities Risk Pool, (WVcorp), under your employer's workers' compensation plan. If you have any questions regarding your claim, or if you have not received your claim number from WVcorp within 5-days of filing your claim, you should contact them directly at:

WVcorp
1819 Electric Rd. STE C
Roanoke, VA 24018
1-888-822-6772

How does the claims process work?

When WVcorp receives your claim, you will receive a claim number and will be assigned to a Claims Specialist. The claim number will identify your claim, and your claim specialist will work with you to ensure that you receive the proper medical care and benefits, and to assist you with an appropriate return to work. Once WVcorp has received and reviewed your completed claim application, you will receive a written decision advising whether your claim has been approved or denied and what medical conditions are covered by your claim. If you disagree with the decision, you have a right to protest the denial by filing a written protest with the Workers' Compensation Office of Judges within 60 days from the day you receive the decision. Protests must be in writing and must include a copy of the decision being protested. The protest must be sent to the following:

Office of Judges
P.O. Box 2233
Charleston, West WV 25328-2233

Copies of your protest must also be sent to your employer and WVcorp at the following address:

WVcorp
1819 Electric Rd. STE C
Roanoke, VA 24018

Under West Virginia law, by filing a workers' compensation claim you irrevocably agree that any physician may discuss, orally or in writing, your medical history and course of treatment with your employer and with WVcorp. This information can include both information regarding your occupational injury or disease, as well as information regarding any prior injury or disease of the portion of your body which is the subject of your workers' compensation claim.

What if I miss work because of my injury?

If you are unable to return to work for four or more consecutive days, you may be eligible for temporary total disability benefits. In order to receive these benefits, your treating physician must certify on the proper forms that you are unable to return to work.

Depending on the nature of your injury you may also be referred by WVcorp for a medical examination, which WVcorp will pay for, to evaluate your medical condition and the progress of your recovery. You may also be referred to a case management professional, who will assist you with your efforts to return to work.

You may also be able to return to work during your recovery period. Your Claims Specialist may consult with your physician and your employer to determine whether your job duties can be modified to accommodate your injury during your recovery period.

How do I choose a Physician?

If your illness or injury is an emergency, you should seek medical treatment at the nearest medical facility that can treat your illness or injury.

For Treatment that is not emergency treatment, please ask your employer for the current network or panel of physicians from which to select. If your employer does not have this information, you may seek treatment from the physician of your choice.

How can I change my Physician?

To change your treating physician, you must obtain prior authorization from your Claims Specialist.

How do I get Medications?

Prior authorization is not required for most medications if they are prescribed within the first two weeks after the date in which you were injured. Certain narcotic medications require prior authorization by your Claims Specialist after this initial two week period, and all mediations require prior authorization by your Claims Specialist after twelve weeks from your date of injury.

If your physician prescribes a brand name medication, and a generic brand of that medication is available, your pharmacist will fill your prescription with the generic brand. If you choose to be provided with a brand-name medication and a generic brand of the prescribed medication is available, you must personally pay the difference between the cost of the generic brand and the brand-name medication.

If you have any questions regarding medications, you should contact your WVcorp Claims Specialist at 1-888-822-6772.

1819 Electric Rd. STE C
Roanoke, VA 24018
1-888-822-6772

Form OIC-WC-1

West Virginia Workers' Compensation
Employees' and Physicians' Report of Occupational Injury or Disease

PLEASE PRINT OR TYPE

Section I — Employee's Claim Information

Insurer: WVCoRP, 1819 Electric Rd. STE C Roanoke, VA 24018 **Third-Party Administrator:**

1. Name: (Last): (First): (M.I):

2. Address: **3. Telephone:** ( ) -

City: State: Zip: **4. Social Security No.:** - -

5. Date of Birth: _____/_____/_____ **6. Sex:** ☐ M ☐ F **7. Marital Status:**

8. Date of Injury or Last Exposure: _____/_____/_____ **Time:** ☐ a.m. ☐ p.m. **9. Time You Began Work on Date of Injury:** ☐ a.m. ☐ p.m.

10. Date You Stopped Working Due to Injury: _____/_____/_____

11. Have You Retired? ☐ yes ☐ no If "yes," what was the date you retired: _____/_____/_____

12. Employer's Name: Supervisor's Name:

Address:

City: State: Zip: Telephone: ( ) -

13. Job Title/Description:

14. Body Part(s) Injured:

15. Describe How Your Injury Occurred (Specify the cause, what you were doing, and equipment/objects involved):

16. Did Injury Occur on Employer's Property? ☐ Yes ☐ No Address where injury occurred:

17. Please Identify Any Witnesses to Your Injury:

I certify that the above is true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I hereby authorize any physician, chiropractor, surgeon, practitioner or other healthcare provider, any hospital, including Veterans' Administration or governmental hospital, and medical service organization, any insurance company, any law enforcement or military agency, any government benefit agency including the Social Security Administration, or any other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to the diagnosis, treatment and/or counseling for HIV/AIDS, psychological conditions, and/or alcohol or substance abuse, for which I must give specific authorization. A Photostat of this authorization shall be as valid as the original.

Employee's Signature: _____ **Date:** _____/ _____/ _____

Section II — All Information Must Be Completed by Initial Healthcare Provider

1. Name of Physician/Hospital: **2. FEIN/Social Security No.:** - -

3. Address:

City: State: Zip: **Telephone:** ( ) -

4. Date of Initial Treatment: _____/_____/_____ **5. Date Patient May Return to Work:** _____/_____/_____

6. Have you advised the patient to remain off work 4 or more days?

☐ Yes. Indicate dates: from to

☐ No. If "no," is the patient capable of ☐ Full Duty ☐ Modified Duty If the patient is capable of returning to modified duty, specify any limitations/restrictions:

7. Condition is a direct result of: ☐ Occupational Injury? ☐ Occupational Disease? ☐ Non-Occupational Condition?

8. Did this injury aggravate a prior injury/disease? ☐ Yes ☐ No. If Yes, explain:

9. Description of injury or occupational disease:

10. Body part(s) injured: **11. ICD9-CM Diagnosis Code(s) in order of severity:**

12. Name of physician referred to: **13. If the patient was hospitalized, where?**

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge I have been informed of my responsibilities under West Virginia's Workers' Compensation Law and agree to abide by such in the administration of services provided thereunder. I understand the submission of false statements or billing may result in prosecution under state and federal law. I further agree to release any office notes/test results immediately to the employer or their representative.

Signature: _____ **Date:** _____/_____/_____

Workers' Compensation Temporary Prescription ID Card

myMatrixx
An Express Scripts Company

WVcorp

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed up the processing of your approved workers' compensation prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx Patient Care Contact Center at 800.945.5951.

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame al Centro de Contacto para Atención a Clientes de myMatrixx, al 800.945.5951.

To the Pharmacist:

myMatrixx, an Express Scripts company administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 15-day supply. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx at 888.786.9640.

Pharmacy Processing Steps

Step 1: Enter BIN number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury YYYYMMDD

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____/_____/_____
MM/DD/YYYY

Group #: M5L2012

Employee Date of Birth: _____/_____/_____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name:

West Virginia Communities Risk Pool

_____

Participating Retail Network Pharmacies

myMatrixx
An Express Scripts Company

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target/CVS
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Walmart
Wegmans
Weis
Winn Dixie