MRCI CLIENT DIRECTED SERVICES

Toll Free: 800-829-7110

Workers' Compensation Insurance Coversheet

Instructional guide for FEIN Employer

Introduction and Purpose: As being the Fiscal Management Services, MRCI would like to provide as much assistance possible when one of your employees becomes injured while working. The purpose of workers' compensation insurance is to provide medical care and compensation to workers who become injured or disabled at work. It is extremely important to educate your employees on this benefit and explain that it is imperative they report all work-related incidents to you within 24 hours of the date of injury/illness. The purpose of this guide is to provide instruction to you and help you understand your role and responsibility.

FEIN Employer Role and Responsibility: When a work accident/injury occurs, it is your responsibility under workers' compensation law to report all incidents and inform MRCI of the event. MRCI files all reports on your behalf. You play a significant role in ensuring the incident is documented thoroughly and accurately. It is imperative that you maintain regular communication with the injured employee and provide MRCI's Human Resources Department with the appropriate forms in order to file with the insurance company (Nonprofit Insurance Trust). If claims are not submitted on time, penalties will apply.

Below is a brief list of steps during the claim process:

#1 When Incident Occurs

- In the event of an accident/injury, the employee must notify you as soon as possible and the employee must complete an incident report within 24 hours of the accident. Employer and employee must sign the back of the form. Please provide full detail of the incident and fax the ***Incident Report Form*** to Human Resources at 507-540-1230. If the employee does not require outside medical attention, you may disregard the rest of the forms included in this packet.

#2 Outside Medical Care (if needed)

- When an employee is injured and would like to seek outside medical treatment, please encourage them to do so. Let them know that their place of care is their choice as long as it is an approved provider. The employee must say to the provider that the injury is work-related and to contact Human Resources for insurance claim information. Direct dial for Human Resources: 507-386-5671. Employee must bring a return to work slip to the employer and the employer needs to send that from via fax to 507-540-1230.

#3 Employer Responsibilities

- Prior to the employee seeking medical care, provide the employee with ***1) Report of Work Ability*** form for the doctor to complete, **2) Pharmacy/ Insurance information form** (in case medication is prescribed) and **3) The Minnesota workers' compensation system informational sheet.**
- Employer must fax the Report of Work Ability form and any other subsequent forms to Human Resources 507-540-1230.

#4 Employee Responsibilities

- Complete incident report and submit to employer. Make sure to provide as much detail as possible and obtain necessary signatures.
- Schedule a visit at medical facility (if wanting to seek treatment).
- Fill prescriptions, if applicable.
- Submit Report of Work Ability form to the employer and faxes a copy to Human Resources at 507-540-1230. Employee must follow any and all restrictions.
- Continue to attend follow-up visits until employee is released of their restrictions and has reached maximum improvement.

If you have questions regarding this process, contact Human Resources at 507-386-5671.

INCIDENT/ ACCIDENT REPORT FORM

Use black ink - NO WHITEOUT

Section 1- Completed by Employee/ Worker

Legal Name of Person Involved: _____ Date of Report: _____

Date of Incident/ Accident: _____ Time of Incident/ Accident: _____ am/pm

Witnesses: Name _____ Phone: (_____)_____

Name _____ Phone: (_____)_____

Specific Location and Address of Accident/Injury:_____

INCIDENT/ACCIDENT

Describe the incident/accident. Use facts and specific detail to describe the incident. (Include what was happening prior to the incident, response to the incident and effect on the person):

_____

_____

_____

_____

Action taken to prevent re-occurrence:

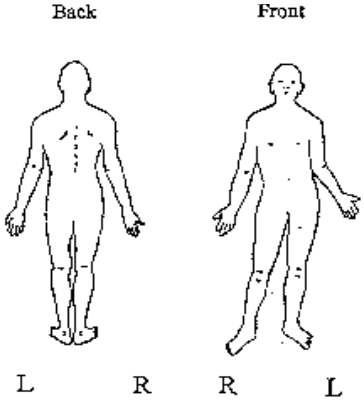
_____

_____

_____

INJURIES ☐ **Yes** ☐ **No** ****** If there are *NO* injuries, please go to Section 3 and 4, if applicable. If injury requires *outside* medical attention please call Human Resources immediately and fill out Section 2.**

Circle site of injury:



Nature of Injury:

☐ Arrived with Injury ☐ Abrasion

☐ Bite ☐ Burn

☐ Bruise(s) ☐ Cut/Laceration Puncture

☐ Other _____

Identify First Aid Provided: _____

Does injury require medical attention (tetanus shot, stitches, etc.)? ☐ Yes ☐ No

Was blood or OPIM present? ☐ Yes ☐ No

Did the First Aid Provider wear gloves? ☐ Yes ☐ No

First Aid Provider: ☐ self ☐ Other _____

EXPOSURE INCIDENT

This ☐ is ☐ is not an exposure incident. **If it is, contact MRCI immediately at 1-800-829-7110 for further instructions.**

Health Care Professional notified immediately and Exposure Incident Report form completed ☐ N/A ☐ Yes

By Whom: _____ Date:_____

INCIDENT/ ACCIDENT REPORT FORM- Continued

Use black ink - NO WHITEOUT

Section 2 - Completed by Employee/ Worker or Supervisor ONLY if incident/accident involved outside medical treatment

OUTSIDE MEDICAL TREATMENT * Please send any doctor's notes or medical treatment regarding this injury to H.R.*

Date of Initial Visit to Medical Provider:_____ Name of Treating Physician/Name of Facility: _____

Address of Facility: _____

Time Employee began work on day of injury: _____ Date of First Day of Lost Time: _____

Supervisor who first received knowledge of injury _____

Date Returned to Work: _____ Please describe injured employee's normal work schedule: _____

Section 3 – Please Sign

SIGNATURES

_____ _____

Signature and Title of Person Completing form Date

Signature of Supervisor/Team Leader/Counselor Date

_____ _____

Signature of Program Manager Date

Signature of Safety Coordinator Date

Safety & Health Investigation completed: ☐ Yes ☐ No

Minnesota Department of Labor and Industry
Workers' Compensation Division
www.dli.mn.gov.wc.wcforms.asp

Report of Work Ability

See Instructions on Reverse Side

RWO1
DO NOT USE THIS SPACE

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

This form must be provided to the employee.
(Minn. Rules 5221.0410, subp. 6)

NOTICE TO EMPLOYEE: YOU MUST PROMPTLY PROVIDE A COPY OF THIS REPORT TO YOUR EMPLOYER OR WORKERS' COMPENSATION INSURER, AND QUALIFIED REHABILITATION CONSULTANT IF YOU HAVE ONE.

Please Submit this form via fax to HR at 507-540-1230, or mail to:
MRCI
15 Map Drive
Mankato, MN 56001

WID or SSN	DATE OF INJURY
EMPLOYEE	
EMPLOYER	
INSURER/SELF-INSURER/TPA NPIA, INC	
INSURER CLAIM NUMBER	

Date of most recent examination by this office _____

Select the appropriate option(s) below and fill in the applicable dates.

1. ☐ Employee is able to work without restrictions as of _____ (date)

2. ☐ Employee is able to work with restrictions, from _____ (date) to _____ (date)

The restrictions are:

3. ☐ Employee is unable to work from _____ (date) to _____ (date)

The next scheduled visit is: ☐ as needed OR _____

NAME (Type or Print)	SIGNATURE	DEGREE
ADDRESS	STATE / LICENSE #/REGISTRATION #	
CITY STATE ZIP CODE	PHONE # (include area code)	DATE SIGNED

INSTRUCTIONS FOR COMPLETING REPORT OF WORK ABILITY

Each health care provider directing the course of treatment for an employee who alleges to have incurred an injury on the job must complete a Report of Work Ability within 10 days of a request for a Report of Work Ability from the insurer, or at the applicable interval (Minn. Rules 5221.0410, subp. 6):

1. every visit if visits are less frequent than one every two weeks;
2. every 2 weeks if visits are more frequent than once every two weeks, unless work restrictions change sooner; and
3. upon expiration of the ending or review date of the restrictions specified in a previous Report of Work Ability.

The Report of Work Ability must either be on this form or in a report that contains the same information. The Report of Work Ability must:

- Identify the employee by name, social security number and date of injury.
- Identify the employer at the time of the employee's claimed work injury.
- If known, identify the workers' compensation insurer at the time of the claimed injury, or the workers' compensation third party administrator. Also indicate this workers' compensation payer's claim number.
- Indicate the date of the most recent examination by this office. The Report of Work Ability should be completed based on this evaluation.
- Identify the appropriate option which best describes the employee's current ability to work by checking box 1, 2 or 3.
    1. If the patient is able to work without restrictions, fill in the beginning date.
    2. If the patient is able to work with restrictions, fill in the date any restriction of work activity is to begin and the anticipated ending or review date. Describe any restrictions in functional terms (e.g., employee can lift up to 20 pounds, 15 times per hour; should have 10 minute break every hour).
    3. If the patient is unable to work at all, fill in the date the restriction of work activity is to begin and the anticipated ending or review date.
- Indicate the date of the next scheduled visit or indicate that additional visits will be scheduled as needed.
- Identify the health care provider completing the report by name, professional degree, license or registration number, address and phone number.
- Include the signature of the health care provider and date of the report.

The health care provider must provide the Report of Work Ability to the employee and place a copy in the medical record.

If you have questions, please call the claim representative or the Department of Labor and Industry, Workers' Compensation Division at (651) 284-5030 or 1-800-342-5354.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.