IPEP REPORTING PROCEDURES

EMPLOYEE IS INJURED

If injury results in death or overnight hospital stay, call IPEP immediately

800-382-8837

COMPLETE FORMS AND SUBMIT TO IPEP

1. First Report of Injury (Completed By Employer)
2. Supervisor's Incident Report (Completed By Employer)
3. Medical Authorization Form (Completed By Employee)

ipepclaims@ipep.com

Fax 765-868-3310

IS TREATMENT REQUIRED?

Yes

Direct employee to designated OCC health clinic or ER

Contact IPEP for any referrals

No

Claim is set up as a record only with IPEP

Contact IPEP as soon as possible if treatment becomes necessary

Fundamentals of Workers Compensation

COMPENSABILITY

INJURY OR ILLNESS

- Arising out of employment
- In the course of employment
- By accident or unforeseen event

THE BURDEN OF PROOF IS ON THE EMPLOYEE

DEFENSES

- Knowingly self inflicts injury
- Intoxication
- Commission of an offense
- Knowing failure to use a safety appliance
- Knowing failure to obey a reasonable written or printed rule of the employer that has been posted in a conspicuous position in the place of work
- Knowing failure to perform any statutory duty

THE BURDEN OF PROOF IS ON THE EMPLOYER

BENEFITS

- **TTD** – 66 2/3% of AWW up to maximum weekly benefit
- **TPD** – 66 2/3% of difference from AWW and actual earnings up to maximum wage
- **DEATH** – 66 2/3% of AWW up to maximum wage for 500 weeks plus burial benefit
- **MEDICAL** – unlimited amount for authorized care with two year statute of limitation
- **PPI** – permanent loss of body function

WORKERS COMPENSATION NOTICE

Your employer is required to provide for payment of benefits under the Workers Compensation and Occupational Diseases Acts of the State of Indiana.

Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

Your employer is self-insured through participation in the Indiana Public Employers' Plan, a risk sharing association of Indiana governmental employers. The Plan's address is:

INDIANA PUBLIC EMPLOYERS' PLAN
PO Box 629, Carmel, IN 46082
Phone: 765-457-9161
1-800-382-8837
Attn: Claims Department

For more information about rights or procedures under the Indiana Workers Compensation system, call or write:

Workers Compensation Board of Indiana
Ombudsmen Division
402 West Washington Street, Room W196
Indianapolis, IN 46204
317-232-3808
1-800-824-2667

Injured Worker's First Fill Prescription Form

Employee Name: _____

Date of Injury:_____ SSN: _____

Injured Worker Instructions

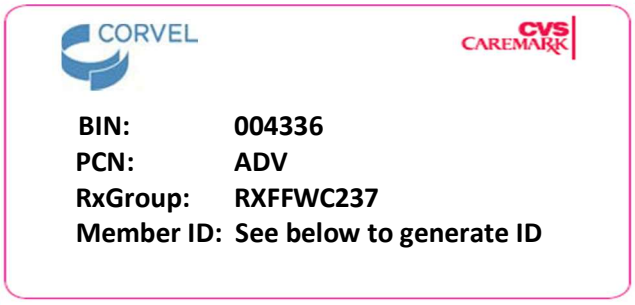
On your first Pharmacy visit, please give this notice to any pharmacy listed on this insert. This will expedite the processing of your approved workers' compensation prescriptions, based on the parameters established by **Indiana Public Employers' Plan (IPEP).** With the CorVel pharmacy program, you do not need to complete any paperwork or claim forms. Simply present this CorVel First Fill Prescription Form to the pharmacy. You should not incur any costs or co-pays at the pharmacy and you will be allowed up to a 14-day supply of most medications.

Notice to Injured Worker and Pharmacy

This temporary First Fill card is only valid if used within 30 days of the reported date of injury. Temporary eligibility through this program allows for a one-time fill of prescription medications. For assistance with processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.**

Pharmacy Instructions

For assistance processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.** Please use the BIN, PCN, and RxGroup number below to process an online/electronic claim to CorVel:



To generate member ID: The Injured Worker's 9 digit social security number plus 8 digit date of injury will be used as their 17 digit **member identification number** when processing their First Fill Prescription: **XXXXXXXXXMMDDYYYY**

Below is a sample listing of some of the over 67,000 Participating Pharmacies in the CorVel Network. Please call **(800)563-8438** for a participating pharmacy near you.

CostCo Pharmacy	H.E.B. Pharmacies	Meijer Pharmacy	Smith's Food & Drug Centers
CVS	Hy-Vee Pharmacy	Publix Pharmacy	Target Pharmacy
Duane Reade	Ingles Pharmacy	Raley's Drug Center	Von's Pharmacy
Drug Mart	Kroger Pharmacy	Rite Aid Pharmacy	Wal-Mart Pharmacy
Fred's Pharmacy	Longs Drug Store	Safeway Pharmacy	Walgreens Pharmacy
Giant Eagle Pharmacy	Marc's Pharmacy	Sav-On Drug Store	Wegman Pharmacy

State Form 34401 (R10 / 1-02)
Please return completed form electronically by an approved EDI process.

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION

Social Security number	Date of birth	Sex	Occupation / Job title	NCCI class code
		☐ Male ☐ Female ☐ Unknown		

Name (*last, first, middle*)	Marital status	Date hired	State of hire	Employee status
	☐ Unmarried ☐ Married ☐ Separated ☐ Unknown			

Address (*number and street, city, state, ZIP code)*	Hrs / Day	Days / Wk	Avg Wg / Wk	☐ Paid Day of Injury ☐ Salary Continued

Telephone number (include area)	Number of dependents	Wage	Per
		$	☐ Hour ☐ Day ☐ Week ☐ Mont

EMPLOYER INFORMATION

Name of employer	Employer ID#	SIC code	Insured report number

Address of employer (*number and street, city, state, ZIP code*)	Location number	Employer's location address (*if different)*
	Telephone number	
	Carrier / Administrator claim number	OSHA log number / Report purpose code

Actual location of accident / exposure (*if not on employer's premises*)

CARRIER / CLAIMS ADMINISTRATOR INFORMATION

Name of Claims Administrator Indiana Public Employers Plan (IPEP)	Carrier federal ID number	Check if appropriate ☐ Self Insurance
Email of Claims Administrator: ipepclaims@ipep.com	☐ Insurance Carrier ☐ Third Party Admin.	Policy / Self-insured number
Telephone number 800-382-8837 765-868-3310 FAX		Policy period From To

Name of agent	Code number

OCCURRENCE / TREATMENT INFORMATION

Date of Inj./ Exp.	Time of occurrence ☐ AM ☐ PM ☐ Cannot be determined	Date employer notified	Type of injury / exposure	Type code

Last work date	Time workday began	Date disability began	Part of body	Part code

RTW date	Date of death	Injury / Exposure occurred on employer's premises? ☐ Yes ☐ No	Name of contact	Telephone number

Department or location where accident / exposure occurred	All equipment, materials, or chemicals involved in accident

Specific activity engaged in during accident / exposure	Work process employee engaged in during accident / exposure

How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.

Cause of injury code

Name of physician / health care provider

Hospital or offsite treatment (*name and address*)

Name of witness	Telephone number	Date administrator notified

Date prepared	Name of preparer	Title	Telephone number

INITIAL TREATMENT
- ☐ No Medical Treatment
- ☐ Minor: By Employer
- ☐ Minor: Clinic / Hospital
- ☐ Emergency Care
- ☐ Hospitalized > 24 Hours
- ☐ Future Major Medical / Lost Time Anticipated

An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13).

INSTRUCTIONS

General Instructions:

1. Please enter information into all of the areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.

2. Enter all dates in MM/DD/YY format.

3. Please return completed form electronically by an approved EDI process.

4. For answers to questions, please call (317) 232-3808.

Definitions:

AGENT NAME AND CODE NUMBER: Enter the name of your insurance agent and his / her code number if known. This information can be found on your insurance policy.

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED: List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and / or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (*e.g. Acetylene cutting torch, metal plate, etc.*).

AVG WG/WK: Claimant's average weekly wage, calculated by totaling the latest 52 weeks of wages (*including overtime, tips, etc.*) and dividing by 52.

CLAIMS ADMINISTRATOR: Enter the name of the carrier, third-party administrator, state fund, or self-insured responsible for administering the claim.

CONTACT NAME / TELEPHONE NUMBER: Enter the name of the individual at the employer's premises to be contacted for additional information (*i.e. Supervisor, HR Person, Nurse, etc.*)

DATE DISABILITY BEGAN: The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwised deigned by statute.

DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED: If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (*e.g. Maintenance, Client's Office, Cafeteria, etc.*).

EMPLOYEE STATUS: Indicate the employee's work status from the following choices: Full-time, Part-time, Apprentice Full-time, Apprentice Part-time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as: (*FT, PT, AFT, APT, VO, SW, PW, OS, DI, RE, NE, or UK*).

HOW INJURY / ILLNESS OCCURRED: Describe the sequence of events leading to the injury or exposure (*e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall*).

NCCI CLASS CODE: A four-digit code classifying the occupation of the claimant.

OCCUPATION / JOB TITLE: Enter the primary occupation of the claimant at the time of the accident or exposure.

PART OF BODY AFFECTED: Indicate the part of body affected by the injury / illness (*e.g. Right forearm, Low Back, etc.*)

REPORT PURPOSE CODE: 00 = Original First Report of Injury; 02 = Updated or Amended First Report.

RTW DATE (*Return to Work Date*): Enter the date following the most recent disability period on which the employee returned to work.

SIC CODE: This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT / EXPOSURE: Describe the specific activity the employee was engaged in during the accident or exposure (*e.g. Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting*).

TYPE OF INJURY / ILLNESS: Briefly describe the nature of the injury or illness (*e.g. Contusion, Laceration, Fracture, etc.*)

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT / EXPOSURE: Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (*e.g. Building maintenance*).

INDIANA PUBLIC EMPLOYERS' PLAN, INC.

SUPERVISOR'S INCIDENT INVESTIGATION REPORT

(Please Complete All Sections)

1. Company or Location | 2. Department | 3. Date of Incident/Day of Week

4. Exact Location of Incident | 5. Time of Occurrence (am/pm) | 6. Date Reported

7. Name of Injured | 8. Occupation | 9. Body Part Affected (See Back)

10. Nature of Injury or Illness (See Back) | 11. Item Inflicting Injury/Illness | 12. Type of Accident (See Back)

13. Person With Most Control of Item 11.

14. Description of the Incident

15. Direct Causes of Incident | 16. Why Each Cause Exists

17. Actions Taken or Needed to Prevent Recurrence | 18. Date Completed

19. Investigated By | 20. Date | 21. Reviewed By | 22. Date

Please mail form to:
ipepclaims@ipep.com

Toll free: l-800-382-8837
Claims Fax: l-765-868-3310
Local: l-765-457-9161

Indiana Public Employers' Plan, Inc.
Please email to:
ipep@ipepclaims.com

Toll free: 1-800-382-8837
Local: 1-765-457-9161
Claims fax: 1-765-868-3310

Adjuster: Claim No:

AUTHORIZATION FOR RELEASE OF MEDICAL, MILITARY, EDUCATION AND WAGE INFORMATION

To any physician, dentist, hospital, health care practitioner, military authority, education authority, employer or insurance carrier:

The requested information is needed to accurately evaluate, adjust and pay the patient's insurance claim.

I hereby authorize any health care professional (including health care physicians, medical practitioners or other health care providers, hospitals, medical attendants, nurses, x-ray technicians, or any other person), military authority, education authority, employer or insurance carrier, to furnish to the insurance company named above or its authorized vendors and representatives, wage loss and individually identifiable health information regarding my injuries, payment, treatment rendered, or health care received or provided. I understand that this authorization is voluntary.

I agree that a photocopy or fax of the original authorization shall have the same force and effect as the original.

I understand that my health care records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

I understand that I may revoke this authorization at any time by notifying the health care professional(s) in writing, but if I do it will not have any affect on any actions taken before receipt of the revocation.

I understand that once disclosed, the information and documentation released may be re-disclosed and may no longer be subject to the HIPAA Privacy Rule.

This disclosure is made at the request of the individual named below for the purposes of evaluation, adjusting and paying an insurance claim.

Unless otherwise required by law, this authorization shall expire upon the final resolution of the insurance claim.

By signing below, the patient acknowledges that he /she has read the fraud statement printed below.

PATIENT OR REP SIGNATURE

PATIENT ADDRESS

PATIENT NAME OR REP (PLEASE PRINT)

CITY, STATE, ZIP

REPRESENTATIVE'S RELATIONSHIP TO PATIENT

PATIENT PHONE NUMBER

DATE

SOC SEC NUMBER

DATE OF BIRTH

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION COMMITS A FELONY.

12103

WAGE STATEMENT

DATE _____ CLAIM NUMBER _____

EMPLOYEE _____ EMPLOYER _____

I have examined our payroll records and the following table shows the weeks worked and the wages earned b the above-named employee during the period stated therein (including bonus and overtime pay).

I have examined our payroll records and find that the above-named employee did not work for said employer for a sufficient period to determine a proper average weekly wage. Therefore, the following table shows the weeks worked and wages earned by _____ a fellow employee of the same class who was similarly engaged by the same employer and who did work a substantial part of the year prior to _____.
(Date of alleged injury)

Position: _____ Signed By: _____

	Week Ending			Days Worked	Amount Paid		Week Ending			Days Worked	Amount Paid
	Month	Day	Year				Month	Day	Year		
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
15						41					
16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					
				Total						**Total $**	
					Entire Total						

Please email form to:
ipepclaims@ipep.com

IPEP

Toll-free: 1-800-382-8837
Claims Fax: 1-765-868-3310
Local: 1-765-457-9161