



Employee Injury Packet



Dealership Name

Claim Coordinator Name & Phone

To the Employee:

- _____ 1. Contact your supervisor to report injury.
- _____ 2. Choose Physician/Medical Clinic from Physician List (*Contact Supervisor or Claim Coordinator for Physician List*)
- _____ 3. Visit Physician as directed – **Give physician this packet every visit**
- _____ 4. Return the completed Injury Packet to your Supervisor or Claim Coordinator following every visit.
- _____ 5. If prescriptions will be necessary, refer to *Express Scripts Prescription Coverage* information sheet inside this packet

To the Physician:

- _____ 1. If a medical referral is necessary contact the employer for a Panel of Physicians.
- _____ 2. Our dealership offers a Return-to-Work Program where we make every effort to promote expeditious recovery and transition back to the workplace. Please complete the attached Medical Treatment & Work Status Form detailing work restrictions & return to Employee (or mail to PMA)

Questions? Contact PMA at 1-888-476-2669

- _____ 3. See address below for filing Medical Bills and/or Medical Reports

The PMA Companies will be responsible for making all compensability decisions regarding this workers compensation claim. If the claim is determined to be compensable all medical bills will be paid by PMA Companies under the VADA Group Self Insurance Association policy. Therefore, please forward all medical billings and medical reports directly to:

***PMA Customer Service Center
PO Box 5231
Janesville, WI 53547-5231***

Please reference the PMA Claim number or the employee's name, date of accident, & SSN

Note: All bills should be sent with appropriate supporting medical reports as they cannot be processed without the appropriate supporting medical reports



Medical Treatment & Work Status Form

Employee Name _____ Dealership _____

To Be Completed By Healthcare Provider

(Please Note: A separate *Medical Treatment & Work Status Form* must be completed for each visit to an approved provider.)

Patient has follow up appointment on _____ () Check if treatment complete
Diagnosis: _____
Treatment (including surgery, physical therapy, medications, and diagnostic procedures):

Medical Recommendations for Return to Work: (Modified duty will be considered for all employees)

WORK STATUS: (Health Care Provider, please check all appropriate boxes)

- Patient released to regular duty on _____ or, Patient expected to return to full duty on _____
- Patient may work transitional/ modified duty as of _____ with restrictions as listed below:

WORK EFFORT LEVEL: (US Dept of Labor Classifications, 3rd Ed. 1993)

- | | |
|---|---|
| <input type="checkbox"/> Sedentary: lift/carry 10 lbs. maximum: walk, stand, sit as needed | <input type="checkbox"/> Medium Heavy: lift/carry occasional 75 lbs. maximum, frequently lift/carry up to 50 lbs. |
| <input type="checkbox"/> Light: lift/carry occasional 20 lbs. maximum; sitting as needed, may lift/carry up to 10 lbs. frequently, walk stand, push, pull (arm or leg controls), may walk/stand to significant degree | <input type="checkbox"/> Heavy: lift/carry occasional 100 lbs. maximum, frequently lift/carry up to 50 lbs. |
| <input type="checkbox"/> Light Medium: lift/carry occasional 35 lbs. maximum, frequently lift/carry up to 20 lbs. | <input type="checkbox"/> Employee can drive to work |
| <input type="checkbox"/> Medium: lift/carry occasional 50 lbs. maximum, frequently lift/carry up to 25 lbs. | <input type="checkbox"/> No reaching above shoulder height |
| <input type="checkbox"/> Medium Heavy: lift/carry occasional 75 lbs. maximum, frequently lift/carry up to 50 lbs. | <input type="checkbox"/> No reaching below waist |
| <input type="checkbox"/> Other restrictions _____ | <input type="checkbox"/> No exposure to dust/fumes |
| | <input type="checkbox"/> No operating vehicles |
| | <input type="checkbox"/> No operating machinery |

Name of Healthcare Provider Practice _____ Phone _____
Signature of Healthcare Provider _____ Date _____

HEALTHCARE PROVIDER: Please forward records and bills from this visit as soon as possible to: PMA – P. O. Box 2854 –Clinton, IA 52733-2854
EMPLOYEE: Return this form to your supervisor/claims coordinator
QUESTIONS: Contact PMA Management Corp. Customer Service: 888-476-2669

To be Completed by Employee (Employee Signature Required)

Name: _____ SSN: _____ Date of Injury: _____ Phone: _____
Home Address: _____ City: _____ State: _____ Zip: _____

I give permission to my physicians or other healthcare providers, hospitals, or clinics to release the information on this form and to release my medical records relating to this injury/illness to my employer, PMA, and any entity responsible for providing services in connection with my workers' compensation claim. I understand this information will be used to assist my employer in evaluating my injury/illness, my work status, and proposed courses of treatment.

Employee Signature: _____ Date: _____

Transitional Duty Provided: _____ Date Transitional Duty Started: _____
Description of Transitional Duty: _____ Expected Completion Date: _____

To be Completed by Supervisor

Signature of Supervisor: _____ Date: _____



Workers Compensation: Express Scripts Prescription Coverage

VADA GSIA provides prescription coverage for your workers' compensation claims through our partnership with PMA & Express Scripts. Virtually all major pharmacies can bill on-line through this network.

Medication prescriptions can be filled with NO MONEY OUT-OF-POCKET.

All claims should be reported immediately. However, if the first trip to the pharmacy is prior to this claim being fully registered in PMA's system, the pharmacy can still process the prescription fill through Express Scripts online through their "FIRST FILL" program if it is during normal business hours. Injured workers should be provided the Express Scripts Workers' Compensation Temporary Prescription ID Card form for their first prescription.

A sampling of the pharmacies that participate is listed below. However, if you don't see one you are looking for listed go to www.express-scripts.com/workerscompensation and click on "Injured Worker? Find a Pharmacy" or call Express Scripts at 888.786.9640 to find a pharmacy close to you.

MAKE COPIES OF THE EXPRESS SCRIPTS WORKERS' COMPENSATION TEMPORARY PRESCRIPTION ID CARD FORM AND SIMPLY GIVE IT TO THE EMPLOYEE WHEN THE INJURY IS REPORTED.

PMA Injured Worker Express Scripts Participating Pharmacies

PHARMACY NAME	
Costco	<p><u>These are just a few MyMatrixx participating pharmacies.</u></p> <p>Go to www.mymatrixx.com and click on "Pharmacy Locator" and "Injured Workers Resources" to find a participating pharmacy near you.</p> <p>PLEASE HAVE YOUR PHARMACY CALL MyMatrixx REGARDING ANY QUESTIONS/AUTHORIZATIONS @ (877) 804-4900</p>
CVS	
EPIC Pharmacy Network	
Giant Food	
Hannaford	
Harris Teeter	
Kmart	
Kroger	
Martins	
Publix	
Rite Aid	
Safeway	
Sam's Club	
Target	
Walgreens	
Wal-Mart	
Wegmans	