BRICKSTREET INJURY KIT

POLICY # WCP7002625

COMPANY NAME School Facility Management / ServiceFM LLC

CONTACT PERSON AND NUMBER Javier Martinez (615) 947-2015

JURISDICTION Nashvillle, TN

Brickstreet® INSURANCE

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BRICKSTREET INJURY KIT SUPERVISOR CHECKLIST

- Secure proper medical care for your employee and inform them if modified/light duty work is available.
- Follow your company's procedure to report the injury. If you are not aware of the procedure, call your supervisor.
- Give this envelope to your employee and ensure they complete the enclosed forms.
- Report the injury to BrickStreet within 24 hours using one of the following methods:

  - **Telephone:** Call 866.45BRICK (866.452.7425), select "policyholder" and option 1 (This is the quickest and most convenient option)
  - **Internet:** File electronically through StreetConnect; contact your agent or BrickStreet's Customer Service Unit for information about becoming a StreetConnect user
  - **Email:** Send an email with the completed First Report of Injury as an attachment to ClaimsIntake@brickstreet.com; visit the specific jurisdiction's website to obtain the First Report of Injury form
  - **Fax:** Send the completed First Report of Injury to 877.293.5513 or 304.941.1151; visit the specific jurisdiction's website to obtain the First Report of Injury form

If you have a StreetConnect account, you also can click the Virtual Claims Kit link, choose the appropriate carrier and jurisdiction and locate the correct form.

INJURED EMPLOYEE CHECKLIST

- [ ] Report all injuries to supervisor
  (Alabama, Georgia, Indiana, Iowa, Kansas, Missouri, North Carolina, Pennsylvania, South Carolina, Tennessee and Virginia allow your employer to either choose your physician or provide you with a list of approved physicians)

- [ ] Obtain either a full-duty release or a completed Physician Statement of Physical Capabilities Form from the doctor (if released for light/modified duty)

- [ ] If released to return to work, return on your next scheduled work day with either your full-duty release or the Physician Statement of Physical Capabilities Form

- [ ] If not released to return to work, you must telephone your supervisor within one business day and provide:
  - Physician's name, address and phone number
  - Date of your next scheduled doctor appointment

- [ ] Return Incident Report to your supervisor upon return or within 24 hours

First Fill Information
BrickStreet

Dear Injured Worker,

Cypress Care has been selected by **BrickStreet** to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply **fill in the form below** and present it at the pharmacy at the time your prescription is filled. This form guarantees that you will have **no out-of-pocket expenses** when you fill your first prescription.

For your convenience, Cypress Care has an extensive network of retail pharmacies. Cypress Care's pharmacy network includes major chain drug stores.

For pharmacy locations, you may also call our toll free number or visit our website at **www.cypresscare.com** and use the pharmacy locator in the quick links section of the home page.

If you have any questions, or would like to learn about our convenient home delivery service, please call our toll-free customer service number: **800.419.7191.**

First Fill Form: Complete and take to your pharmacy

Bin #: 010876 Group Number: **BRICKSTREET**

Member ID:		Last 4 digits of SSN + date of injury; No spaces (i.e. 9999050206)
Member Name:		Injured worker's first & last name
Employer Name:		
Date of Injury:		

Pharmacy Help Desk: 800.419.7191

PLEASE NOTE: This form allows you to fill your initial prescriptions with a maximum cost of **$150** per prescription and no more than a **14 day supply** per prescription. Once your claim has been reviewed, you will be sent a new card in the mail. If you do not receive the pharmacy card, please call us at 800.419.7191.

Medical Records Release

TO: Any licensed physician, chiropractor, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or other organization, institution, or person that has any records or knowledge of my health, history, condition, or well-being

In accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state privacy laws and regulations, I, [Claimant Name], Claim [claim#], hereby authorize the use or disclosure of my individually identifiable health information described below to **[Data Retriever for Full Company Name], P.O. Box 3151 Charleston, WV 25322**.

For purposes of this Authorization, individually identifiable health information shall mean: Any and all of my personal health information created, received or obtained, including any medical or dental records, x-ray or radiology films, pathology materials, MedFlight reports, insurance-related documents and benefit forms, or any other medically-related record or item that relates to my physical health or condition, the provision of health care to me, or the payment for my care, as the foregoing information relates to the assessment, treatment, or recordation of history related to any injury to me or any disease that affects me regardless of the time or cause of the onset of said injury or disease.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, psychological or psychiatric treatment, social services counseling, communicable diseases or infections, tuberculosis and hepatitis. Such records will be released through this authorization unless otherwise indicated. **Do not release any of the following information if an "x" appears before the description.**

__HIV/AIDS __Behavioral Health __Drug & Alcohol __Genetic History

I further authorize Recipient to use, disclose, or re-disclose any and all of my above-described health information and to make copies thereof for purposes of evaluating and administrating an insurance claim I have filed with Recipient. I understand that my health information may be re-disclosed by Recipient and may then no longer be protected by any applicable federal or state privacy laws or regulations.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Recipient at the address listed above. I understand that my revocation will only be effective after it is received by Recipient and that the revocation will not apply to information that has already been released in response to this authorization.

This authorization shall expire on: ___/___/____. If no date is specified, this authorization shall expire one year from the date it is signed. Any disclosures made prior to my revocation or prior to the expiration of this authorization will not be affected by my revocation or by the expiration of this authorization.

I understand and agree that a photocopy or electronically reproduced copy of the original of this authorization shall have the same effect as an original.

_____ _____
Signature of Individual Date

_____ _____/_____/_____
Social Security Number Date of Birth

_____
Signature of Personal Representative, Estate Representative, or Guardian (Provide documentation of authority to act for individual

Brickstreet INSURANCE

Incident Report

To be completed by injured worker immediately following incident

WHEN

Date of incident:	Time of incident:
Was incident reported immediately to supervisor? ☐ YES ☐ NO	If not, please explain:

WHO

Employee name:		Job title:
Department:	Age:	Length of employment:
Names of witnesses (attach witness statements separately, if available):		

INJURY

Describe how your injury occurred (specify the cause, what you were doing, and equipment/objects involved):		
Nature/extent of injuries (include body part injured):		
Exact location where accident occurred (collect and include photographs):		
Was first aid administered? ☐ YES ☐ NO		
Did you see a doctor about your injury? ☐ YES ☐ NO	If yes, please list the following information:	
Doctor's name:		Doctor's phone number:
Date of visit:		Time of visit:

CAUSES

Direct cause of injury (event that directly caused injury):	Was a third party involved?
	Was equipment involved in (or did it cause) the injury? ☐ YES ☐ NO

SUGGESTIONS

What could have been done to prevent this injury?

SIGNATURES

Employee Signature	Date
Supervisor's Signature	Date
Witness Signature(s)	Date

Return this form to your supervisor.

Physician Statement Of Physical Capabilities

Return completed form to:

BrickStreet Insurance
P.O. Box 3151
Charleston, WV 25332-3151

Claimant Name	Claim Number	Date of Injury

Please complete this form after your examination of the patient. Indicate the patient's restrictions, if any, including modified hours, duties, environmental factors and any other information pertinent to this employee's healthy recovery and possible early return to work.

Medical Diagnosis

Work Postures (Work is performed in which postures? Please indicate frequency.)				
Standing	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
Sitting	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
Walking	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
Climbing	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
Kneeling	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
Pushing	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
Pulling	☐ Continuous	☐ Frequent	☐ Infrequent	☐ Never
	(6 – 8 hours a day)	(2 – 6 hours a day)	(0 – 2 hours a day)	

Please indicate the extent to which the employee can perform the following:
(N = Never, O = Occasionally, F = Frequently, C = Continuously)

Lifting / Carrying	**N**	**O**	**F**	**C**	**Activity**	**N**	**O**	**F**	**C**
10 lbs. or less					Bend				
11 – 20 lbs.					Squat				
21 – 40 lbs.					Kneel				
41 – 60 lbs.					Twist / Turn				
61 – 100 lbs.					Climb				
Pushing / Pulling					Crawl				
13 – 25 lbs.					Reach Above Shoulder				
26 – 40 lbs.					Type / Keyboard				
41 – 60 lbs.					**Driving**				
61 – 100 lbs.					Automatic				
100+ lbs.					Standard				
Upper Extremities	**Yes**		**No**		**Operate foot controls or motor vehicles**	**Yes**		**No**	
Simple Grasping	☐ R	☐ L	☐ R	☐ L		☐ R	☐ L	☐ R	☐ L
Pushing / Pulling	☐ R	☐ L	☐ R	☐ L	Simultaneous	☐ Yes		☐ No	

Comments

Physician Name	Physician Telephone
Date released with above restrictions	Date released for full-duty work
Physician Signature	Date