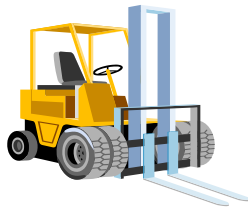




WORKERS' COMPENSATION



"Your safety is everyone's responsibility, especially yours"

PROCEDURE MANUAL

SANTA MONICA COLLEGE EMPLOYEES

IN CASE OF WORK INJURY OR ILLNESS



REPORT TO YOUR SUPERVISOR



**OBTAIN REFERRAL FORM FROM
SUPERVISOR FOR
BRENTVIEW MEDICAL OR
MIDWAY INDUSTRIAL HEALTH CARE
SERVICES**

OR



GO TO HEALTH SERVICES

-Business Hours-

Monday-Thursday

8:00 a.m. – 7:30 p.m.

Friday

8:00 a.m. – 2:30 p.m.

If Health Services is closed, Campus Police will provide the authorization/referral form for medical treatment and work injury claim forms.

MEDICAL TREATMENT

**Brentview Medical
11611 San Vicente Blvd.
Los Angeles, CA 90049
(310) 820-0013**

BUSINESS HOURS:

**Monday – Friday
8:00 a.m. – 8:00 p.m.
Saturday & Sunday
9:00 a.m.-4:00 p.m.**

After Office Hours:

Please call (310) 820-0013 to have physician paged or go to nearest ER. FOLLOW-UP at Brentview Medical

**Parking will be validated for work related injuries only
See additional parking instructions on Treatment Authorization form.**

Emergencies-call Campus Police at Ext. 4300

**PLEASE DO NOT GO TO YOUR PRIMARY CARE PHYSICIAN FOR WORK INJURIES UNLESS YOU AND YOUR PRIMARY CARE PHYSICIAN HAVE COMPLETED AND RETURNED THE WORKERS' COMPENSATION PRE-DESIGNATION OF PERSONAL PHYSICIAN FORM PRIOR TO AN INJURY
(SEE PAGE 6 - *TREATING PHYSICIAN*).**

MEDICAL TREATMENT

Midway Industrial Health Care Services (IHCS)

5901 W. Olympic Blvd., Suite 203

Los Angeles, CA 90036

(323) 930-1331

BUSINESS HOURS:

Monday – Friday

8:30 a.m. – 5:00 p.m.

After Office Hours:

Please call (310) 202-4745 and go to Southern California Hospital at Culver City Emergency Room-3828 Delmas Terrace, Culver City, CA., or (323) 932-5104 and go to Olympia Medical Center-5900 W. Olympic Blvd., Los Angeles, CA.

FOLLOW-UP at Midway IHCS

See parking instructions on Treatment Authorization form.

(Employee will get reimbursed for parking charges)

Emergencies-call Campus Police at Ext. 4300

PLEASE DO NOT GO TO YOUR PRIMARY CARE PHYSICIAN FOR WORK INJURIES UNLESS YOU AND YOUR PRIMARY CARE PHYSICIAN HAVE COMPLETED AND RETURNED THE WORKERS' COMPENSATION PRE-DESIGNATION OF PERSONAL PHYSICIAN FORM PRIOR TO AN INJURY

(SEE PAGE 6 - *TREATING PHYSICIAN*).

Introduction

Santa Monica College Workers' Compensation Insurance provides benefits to those employees who suffer injury/illnesses which are determined to have originated in the workplace. Department Supervisors/Managers are responsible for providing Risk Management with appropriate documentation when such injuries/illnesses are reported. This manual is to provide useful information regarding workers' compensation procedures.

Reporting an Injury/Illness:

Any occurrence, which results in injury, illness, exposure or death arising out of or in the course of employment, should be reported to the supervisor immediately to make sure that he/she receives appropriate care.

Claim Forms:

Several Workers' Compensation Claim forms will need to be completed during the duration of the workers' compensation claim. Timely submission of all forms is required by law and should be submitted to Risk Management immediately.

During normal business hours the supervisor will give the employee the (DWC-1) Workers' Compensation Claim form (**Sample 1**); SMCCD Report of Work Injury/Illness form (**Sample 2**) and PRIME Advantage MPN Employee Notification (**Sample 3**). The employee must fill out the top portion of both forms (questions 1 through 8 on the claim form (DWC-1), keep the green copy (employee's temporary receipt), and Part I on the SMCCD Report of Injury form). The supervisor must complete the bottom portion of the Claim form (questions 9 through 13) and the bottom portion of the SMCCD Report of Injury form, retain the yellow copy and send the remaining copies to Risk Management. Risk Management will complete the bottom portion of the claim form (questions 14 through 18) and will send a completed copy to the employee. If the injury does not occur during normal business hours, the employee should report to the Campus Police Office to pick up the required forms. It is also important for the employee to receive and review the MPN information/Covered Employee Notification of Rights Material (sign, date and return top page to Risk Management).

Medical Treatment:

If immediate, non-emergency medical treatment is needed, the employee will be referred to either Brentview Medical or Midway Industrial Health Care Services. The employee is entitled choose preferred medical clinic. *Treatment Referral* forms (**Sample 4 & 5**) should be completed and signed by Risk Management, authorized Supervisor, Health Office, Campus Police, or Human Resources (V.P., Dean, or Director). Employee **MUST** take the completed Referral form to Brentview Medical or Midway IHCS for medical treatment. After normal business hours, contact Campus Police to report the injury and to obtain a *Treatment Referral* and additional work injury forms.

Employee should also be given a copy of the myMatrixx/PRIME-Rx (**Sample 6**) prior to going to the medical facility. The Express Scripts is a temporary prescription card that can be used for any medication prescribed by the physician.

Treating Physician:

The employee will be *referred* to Santa Monica College's Frontline Provider treating physicians (Brentview Medical or Midway IHCS), *unless* he/she has pre-designated his/her personal physician by submitting the *Workers' Compensation: Pre-Designation of Personal Physician* form (**Sample 7**). The pre-designation form must be on file in the District's Risk Management office **prior** to an injury/illness. ("Personal Physician" is defined as the employee's regular physician and/or surgeon, who have previously directed the medical treatment of the employee, who retains the employee's medical records, including his or her medical history, and has agreed to treat the employee in the event of an industrial accident).

Change in Medical Status:

Any change in the injured employee's status should be reported to the supervisor, Risk Management and Human Resources. If the injured employee has not been cleared to return to work, he/she will need to be cleared to return to work with or without restrictions by the treating physician.

IMPORTANT! INJURED EMPLOYEE MUST NOT TAKE TIME OFF FROM WORK UNLESS THE AUTHORIZED TREATING PHYSICIAN CERTIFY ON THE WORK STATUS REPORT THAT THE EMPLOYEE IS UNABLE TO RETURN TO WORK FOR A WORK-RELATED INJURY. OTHERWISE, LOSS TIME WILL BE TAKEN FROM AVAILABLE SICK LEAVE.

Employee will not receive any reimbursement for certified work injury absence until the workers' compensation claim has been accepted by the Insurance Administrator. Copies of all documentation must be sent to Risk Management, including the "Release to Return to Work". The "Release to Return to Work" should state with/without restrictions. Restrictions must get cleared with the immediate supervisor and Human Resources to ensure they are compatible with the employee's assigned duties. *Employees may be asked to perform different duties within their job classification that are more appropriate for the restrictions, on a temporary basis.*

Early Return To Work

Departments are obligated to attempt, in good faith, to provide meaningful temporary work to those employees who are placed on restricted duties by their physician. The objective of the Early Return to Work Program (RTW) is to return Santa Monica College employees to safe and productive work as soon as medically possible following an injury or illness. Please contact Risk Management or Human Resources for additional information on Early RTW.

Declination of Workers' Compensation Benefits

You have the right to decline from filing a workers' compensation claim. This means, no further treatment is needed and you have no desire to proceed with filing a claim. If you wish not to proceed, please complete the Declination of Workers' Compensation Benefits form and return it to Risk Management immediately (**Sample 8**).

Please contact Risk Management at Ext. 4102, if you have any additional questions regarding workers' compensation procedures or if you need to request workers' compensation claim forms. Forms are also available outside the Risk Management Office.

IN AN EMERGENCY, PLEASE FOLLOW THE EMERGENCY PROCEDURES POSTED IN YOUR DEPARTMENT OR CALL CAMPUS POLICE AT EXTENSION 4300.

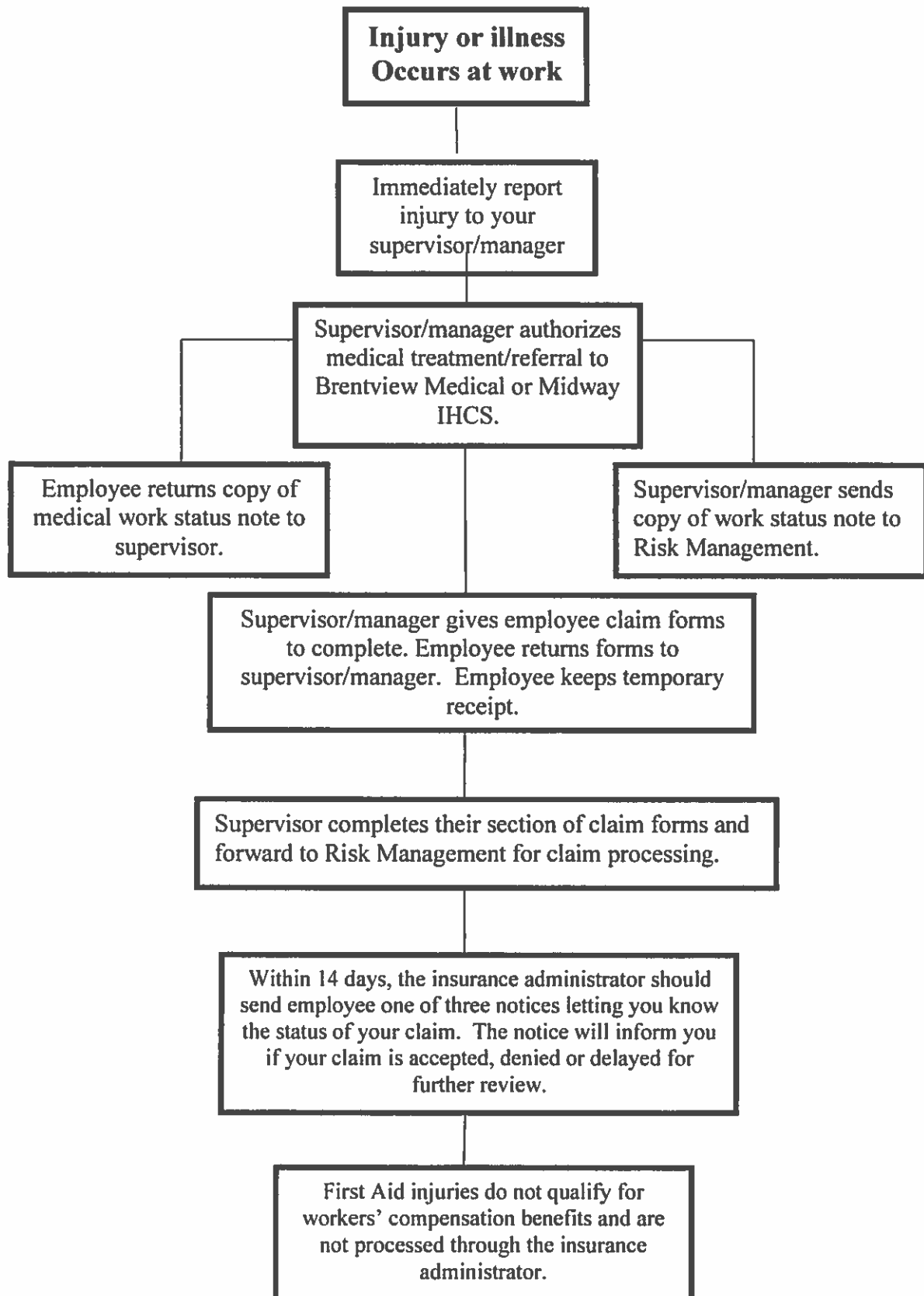
FLOWCHART & SAMPLE ATTACHMENTS

FC-Employee Workers' Compensation Claim Process

1. Workers' Compensation Claim Form (DWC 1)
2. Report of Work Injury/Illness
3. PRIME Advantage MPN-Employee Notification
4. Brentview Medical Treatment Authorization Form
5. Midway Industrial Health Care Services
6. PRIME Workers' Compensation Temporary Prescription Services ID
7. Workers' Compensation: Pre-Designation of Personal Physician
8. Declination of Workers' Compensation Benefits

WC-procdr.manual-2020

EMPLOYEE WORKERS' COMPENSATION CLAIM PROCESS



SAMPLE - 1

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION



Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACION AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACION DEL TRABAJADOR (DWC 1)

Employee: Complete the "Employee" section and give the form to your employer. Keep a copy and mark it "Employee's Temporary Receipt" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at (800) 736-7401. An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Empleado: Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la División de Compensación al Trabajador al (800) 736-7401 para oír información grabada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonía".

Employee—complete this section and see note above

Empleado—complete esta sección y note la notación arriba.

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
 2. Home Address. *Dirección Residencial.* _____
 3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
 4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
 5. Address and description of where injury happened. *Dirección/lugar dónde ocurrió el accidente.* _____
 6. Describe injury and part of body affected. *Describe la lesión y parte del cuerpo afectada.* _____
 7. Social Security Number. *Número de Seguro Social del Empleado.* _____
 8. Check if you agree to receive notices about your claim by email only. *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____
- You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. Empleador—complete esta sección y note la notación abajo.

10. Name of employer. *Nombre del empleador.* _____
11. Address. *Dirección.* _____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros* _____
16. Insurance Policy Number. *El número de la póliza de Seguro* _____
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de **un día hábil** desde el momento de haber sido recibida la forma del empleado.

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

- Employer copy/Copia del Empleador Employee copy/Copia del Empleado Claims Administrator/Administrador de Reclamos Temporary Receipt/Recibo del Empleado

SANTA MONICA COMMUNITY COLLEGE DISTRICT
REPORT OF WORK INJURY/ILLNESS

Part I (Employee to complete)

Employee's Name (Last) (First) Date of Birth

Home Address (Street) (City) (Zip) Phone Number

Date of accident (M/D/Y) Time am/pm. Location injury occurred

Sex Occupation Dept.

Certificated Classified Full-time Part-time Temp Hourly

Did employee remain on the job? Was employee taken/referred to a doctor? Yes No

Name and address of Doctor/Hospital

Describe injury, e.g. strain, cut, etc. Part of body affected, e.g. wrist, back, etc.

What was employee doing when injured? (Please be specific. Identify tools, equipment or material being used.)

How did the accident happen? (Tell where, what and how it happened)

Employee signature Date

Part II (Supervisor to complete)

Comments

What machine, tool, substance or object was most closely connected with accident?

Was injury due to a contributory act of the employee? /an overt act by another employee/Student?

Witnesses

Was injury caused by unsafe conditions? If yes, has unsafe conditions been corrected?

How can a recurrence be prevented?

Cause can be corrected by: Employee Supervision Maintenance

Signed by supervisor Date

Forward original to RISK MANAGEMENT WITHIN 24 HOURS OF ACCIDENT
Supervisor to retain yellow copy



Important Information about Medical Care if you have a Work-Related Injury or Illness

Complete Written Employee Notification regarding Medical Provider Network
(Title 8, California Code of Regulations Section 9767.12)

California law requires your employer to provide and pay for medical treatment if you are injured at work. Your employer has chosen to provide this medical care by using a Workers' Compensation physician network called a Medical Provider Network (MPN). This MPN is administered by Harbor Health Systems.

This notification tells you what you need to know about the MPN program and describes your rights in choosing medical care for work-related injuries and illnesses.

- **What happens if I get injured at work?**

In case of an emergency, you should call 911 or go to the closest emergency room.

If you are injured at work, notify your employer as soon as possible. Your employer will provide you with a claim form. When you notify your employer that you have had a work-related injury, your employer or insurer will make an initial appointment with a doctor in the MPN.

- **What is an MPN?**

A Medical Provider Network (MPN) is a group of health care providers (physicians and other medical providers) used by YOUR EMPLOYER to treat workers injured on the job. MPNs must allow employees to have a choice of provider(s). Each MPN must include a mix of doctors specializing in work-related injuries and doctors with expertise in general areas of medicine.

- **What MPN is used by my employer?**

Your employer is using the PRIME Advantage MPN Powered by Harbor Health Systems MPN with the identification number 2358. You must refer to the MPN name and the MPN identification number whenever you have questions or requests about the MPN.

- **Who can I contact if I have questions about my MPN?**

The MPN Contact listed in this notification will be able to answer your questions about the use of the MPN and will address any complaints regarding the MPN.

The contact for your MPN is:

Name: Harbor Health Systems MPN Contact
 Title: MPN Contact
 Address: PO Box 54770, Irvine, CA 92619-4770
 Telephone Number: (888) 626-1737
 Email address: MPNcontact@harborsys.com

General information regarding the MPN can also be found at the following website: www.harborsys.com/Keenan

- **What if I need help finding and making an appointment with a doctor?**

The MPN's Medical Access Assistant will help you find available MPN physicians of your choice and can assist you with scheduling and confirming physician appointments. The Medical Access Assistant is available to assist you Monday through Saturday from 7am-8pm (Pacific) and schedule medical appointments during doctors' normal business hours. Assistance is available in English and in Spanish.

The contact information for the Medical Access Assistant is:

Toll Free Telephone Number: (855) 521-7080

Fax Number: (703) 673-0181

Email Address: MPNMAA@harborsys.com

- **How do I find out which doctors are in my MPN?**

You can get a regional list of all MPN providers in your area by calling the MPN Contact or by going to our website at: www.harborsys.com/Keenan. At minimum, the regional list must include a list of all MPN providers within 15 miles of your workplace and/or residence or a list of all MPN providers within the county where you live and/or work. You may choose which list you wish to receive. You also have the right to obtain a list of all the MPN providers upon request.

You can access the roster of all treating physicians in the MPN by going to the website at www.harborsys.com/Keenan.

- **How do I choose a provider?**

Your employer or the insurer for your employer will arrange the initial medical evaluation with an MPN physician. After the first medical visit, you may continue to be treated by that doctor, or you may choose another doctor from the MPN. You may continue to choose doctors within the MPN for all of your medical care for this injury.

If appropriate, you may choose a specialist or ask your treating doctor for a referral to a specialist. Some specialists will only accept appointments with a referral from the treating doctor. Such specialist might be listed as "by referral only" in your MPN directory.

If you need help in finding a doctor or scheduling a medical appointment, you may call the Medical Access Assistant.

- **Can I change providers?**

Yes. You can change providers within the MPN for any reason, but the providers you choose should be appropriate to treat your injury. Contact the MPN Contact or your claims adjuster if you want to change your treating physician.

- **What standards does the MPN have to meet?**

The MPN has providers for the entire State of California.

The MPN must give you access to a regional list of providers that includes at least three physicians in each specialty commonly used to treat work injuries/illnesses in your industry. The MPN must provide access to primary treating physicians within 30 minutes or 15 miles and specialists within 60 minutes or 30 miles of where you work or live.

If you live in a rural area or an area where there is a health care shortage, there may be a different standard.

After you have notified your employer of your injury, the MPN must provide initial treatment within 3 business days. If treatment with a specialist has been authorized, the appointment with the specialist must be provided to you within 20 business days of your request.

If you have trouble getting an appointment with a provider in the MPN, contact the Medical Access Assistant.

If there are no MPN providers in the appropriate specialty available to treat your injury within the distance and timeframe requirements, then you will be allowed to seek the necessary treatment outside of the MPN.

- **What if there are no MPN providers where I am located?**

If you are a current employee living in a rural area or temporarily working or living outside the MPN service area, or you are a former employee permanently living outside the MPN service area, the MPN or your treating doctor will give you a list of at least three physicians who can treat you. The MPN may also allow you to choose your

own doctor outside of the MPN network. Contact your MPN Contact for assistance in finding a physician or for additional information.

- **What if I need a specialist that is not available in the MPN?**

If you need to see a type of specialist that is not available in the MPN, you have the right to see a specialist outside of the MPN.

- **What if I disagree with my doctor about medical treatment?**

If you disagree with your doctor or wish to change your doctor for any reason, you may choose another doctor within the MPN.

If you disagree with either the diagnosis or treatment prescribed by your doctor, you may ask for a second opinion from another doctor within the MPN. If you want a second opinion, you must contact the MPN contact or your claims adjuster and tell them you want a second opinion. The MPN should give you at least a regional or full MPN provider list from which you can choose a second opinion doctor. To get a second opinion, you must choose a doctor from the MPN list and make an appointment within 60 days. You must tell the MPN Contact of your appointment date, and the MPN will send the doctor a copy of your medical records. You can request a copy of your medical records that will be sent to the doctor.

If you do not make an appointment within 60 days of receiving the regional provider list, you will not be allowed to have a second or third opinion with regard to this disputed diagnosis or treatment of this treating physician.

If the second opinion doctor feels that your injury is outside of the type of injury he or she normally treats, the doctor's office will notify your employer or insurer and you. You will get another list of MPN doctors or specialists so you can make another selection.

If you disagree with the second opinion, you may ask for a third opinion. If you request a third opinion, you will go through the same process you went through for the second opinion.

Remember that if you do not make an appointment within 60 days of obtaining another MPN provider list, then you will not be allowed to have a third opinion with regard to this disputed diagnosis or treatment of this treating physician.

If you disagree with the third-opinion doctor, you may ask for an MPN Independent Medical Review (IMR). Your employer or MPN Contact will give you information on requesting an Independent Medical Review and a form at the time you select a third-opinion physician.

If either the second or third-opinion doctor or Independent Medical Reviewer agrees with your need for a treatment or test, you may be allowed to receive that medical service from a provider within the MPN, or if the MPN does not contain a physician who can provide the recommended treatment, you may choose a physician outside the MPN within a reasonable geographic area.

- **What if I am already being treated for a work-related injury before the MPN begins?**

Your employer or insurer has a "Transfer of Care" policy which will determine if you can continue being temporarily treated for an existing work-related injury by a physician outside of the MPN before your care is transferred into the MPN.

If your current doctor is not or does not become a member of the MPN, then you may be required to see a MPN physician. However, if you have properly predesignated a primary treating physician, you cannot be transferred into the MPN. (If you have questions about predesignation, ask your supervisor.)

If your employer decides to transfer you into the MPN, you and your primary treating physician must receive a letter notifying you of the transfer.

If you meet certain conditions, you may qualify to continue treating with a non-MPN physician for up to a year before you are transferred into the MPN. The qualifying conditions to postpone the transfer of your care into the MPN are set forth in the box below.

Can I Continue Being Treated By My Doctor?

You may qualify for continuing treatment with your non-MPN provider (through transfer of care or continuity of care) for up to a year if your injury or illness meets any of the following conditions:

- **(Acute)** The treatment for your injury or illness will be completed in less than 90 days;
- **(Serious or Chronic)** Your injury or illness is one that is serious and continues for at least 90 days without full cure or worsens and requires ongoing treatment. You may be allowed to be treated by your current treating doctor for up to one year, until a safe transfer of care can be made.
- **(Terminal)** You have an incurable illness or irreversible condition that is likely to cause death within one year or less.
- **(Pending Surgery)** You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN effective date, or the termination of contract date between the MPN and your doctor.

You can disagree with your employer's decision to transfer your care into the MPN. If you don't want to be transferred into the MPN, ask your primary treating physician for a medical report on whether you have one of the four conditions stated above to qualify for a postponement of your transfer into the MPN.

Your primary treating physician has 20 days from the date of your request to give you a copy of his/her report on your condition. If your primary treating physician does not give you the report within 20 days of your request, the employer can transfer your care into the MPN and you will be required to use an MPN physician.

You will need to give a copy of the report to your employer if you wish to postpone the transfer of your care. If you or your employer disagrees with your doctor's report on your condition, you or your employer can dispute it. See the complete Transfer of Care policy for more details on the dispute resolution process.

For a copy of the Transfer of Care policy, in English or Spanish, ask your MPN Contact.

• **What if I am being treated by a MPN doctor who decides to leave the MPN?**

Your employer or insurer has a written "Continuity of Care" policy that will determine whether you can temporarily continue treatment for an existing work injury with your doctor if your doctor is no longer participating in the MPN.

If your employer decides that you do not qualify to continue your care with the non-MPN provider, you and your primary treating physician must receive a letter notifying you of this decision.

If you meet certain conditions, you may qualify to continue treating with this doctor for up to a year before you must choose a MPN physician. These conditions are set forth in the, "***Can I Continue Being Treated By My Doctor?***" box above.

You can disagree with your employer's decision to deny you Continuity of Care with the terminated MPN provider. If you want to continue treating with the terminated doctor, ask your primary treating physician for a medical report on whether you have one of the four conditions stated in the box above to see if you qualify to continue treating with your current doctor temporarily.

Your primary treating physician has 20 days from the date of your request to give you a copy of his/her medical report on your condition. If your primary treating physician does not give you the report within 20 days of your request, your employer's decision to deny you Continuity of Care with your doctor who is no longer participating in the MPN will apply, and you will be required to choose a MPN physician.

You will need to give a copy of the report to your employer if you wish to postpone the selection of an MPN doctor treatment. If you or your employer disagrees with your doctor's report on your condition, you or your employer can dispute it. See the complete Continuity of Care policy for more details on the dispute resolution process.

For a copy of the Continuity of Care policy, in English or Spanish, ask your MPN Contact.

- **What if I have questions or need help?**

- **MPN Contact:** You may always contact the MPN Contact if you have questions about the use of the MPN and to address any complaints regarding the MPN.
- **Medical Access Assistants:** You can contact the Medical Access Assistant if you need help finding MPN physicians and scheduling and confirming appointments.
- **Division of Workers' Compensation (DWC):** If you have concerns, complaints or questions regarding the MPN, the notification process, or your medical treatment after a work-related injury or illness, you can call the DWC's Information and Assistance office at 1-800-736-7401. You can also go to the DWC's website at www.dir.ca.gov/dwc and click on "medical provider networks" for more information about MPNs.
- **Independent Medical Review:** If you have questions about the MPN Independent Medical Review process contact the Division of Workers' Compensation's Medical Unit at:

DWC Medical Unit
P.O. Box 71010
Oakland, CA 94612
(510) 286-3700 or (800) 794-6900

Keep this information in case you have a work-related injury or illness.



URGENT CARE & OCCUPATIONAL MEDICINE

TREATMENT AUTHORIZATION

(Please select which location by checking the box)

DATE: _____
EMPLOYEE (company name): _____
EMPLOYER (address & phone): _____
AUTHORIZED BY (name & title): _____
SIGNATURE: _____
WORKERS COMP. CARRIER: _____
POLICY#: _____
AUTHORIZED BODY PART: _____
SERVICE REQUESTED: _____

- Treatment for work related Injury
Pre-placement Physical
Spirometry/Pulmonary Function Test
D.O.T. Physical (Dept. of Transportation)
Other (specify):
EKG/Stress Test
Return to work exam
Drug Screening

TO HOSPITAL EMERGENCY ROOM: Please refer patient to Brentview Medical for all follow up care.

Questions? Please call 310-820-0013 or email staff@BrentviewMedical.com

BRENTVIEW MEDICAL - BRENTWOOD
11611 SAN VICENTE BLVD., GROUND FLOOR
LOS ANGELES, CA 90049
CROSS STREET: Bringham Ave. (2 blocks east of Barrington)
P: 310-820-0013 | F: 310-207-2630

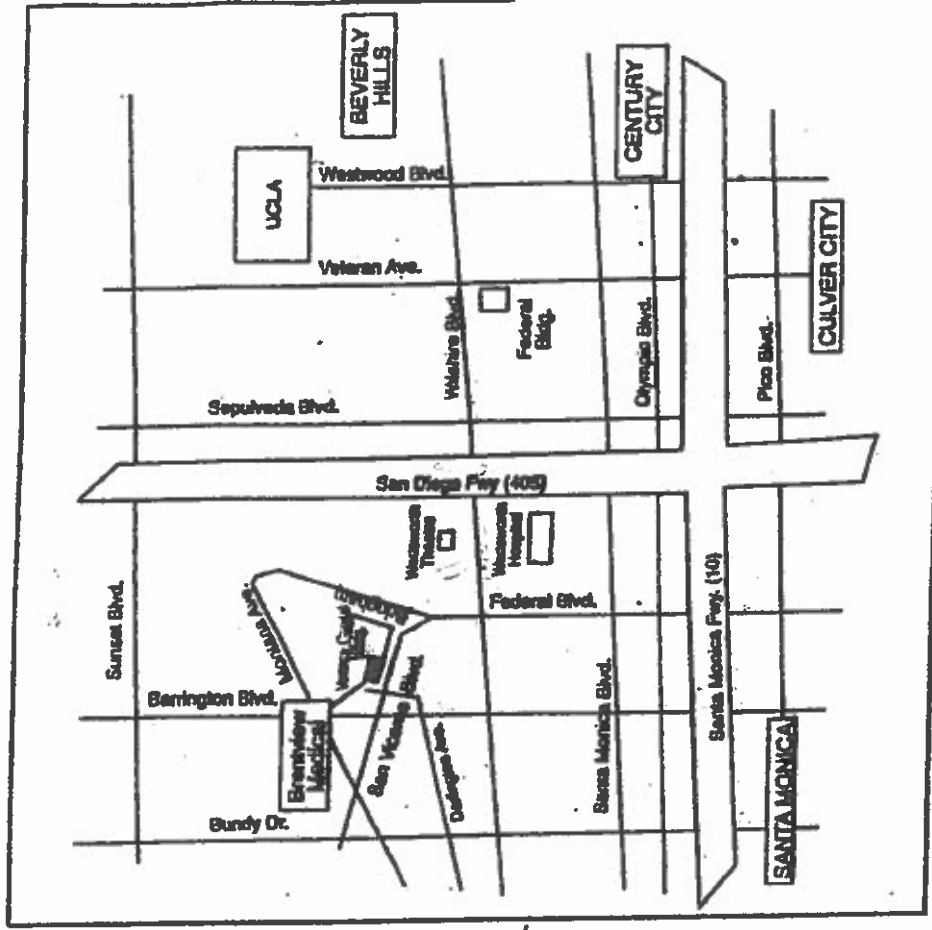
PARKING: We validate parking for work related injuries ONLY. Drive 1 block west to Brentwood Gardens (3 story white building) 11677 San Vicente Blvd. (Turn right into the 2nd driveway before Barrington Ave.) Leave your car with the valet and make sure we stamp your ticket.
NOTE: There are 2 San Vicente Blvd.'s In L.A.

BRENTVIEW MEDICAL - WEST HOLLYWOOD
8264 SANTA MONICA BLVD.
WEST HOLLYWOOD, CA 90046
CROSS STREET: Harper Ave. (2 blocks east of La Cienega)
P: 323-522-2222 | F: 323-654-2221

PARKING: There is free parking located directly behind the building & in the residential area surrounding the clinic.

Brentview Medical

11611 San Vicente Blvd., Ground Floor, Los Angeles, CA 90049
Telephone: (310) 820-0013 Fax: (310)207-2630
www.BrentviewMedical.com



WE VALIDATE PARKING FOR ALL WORK RELATED INJURIES.

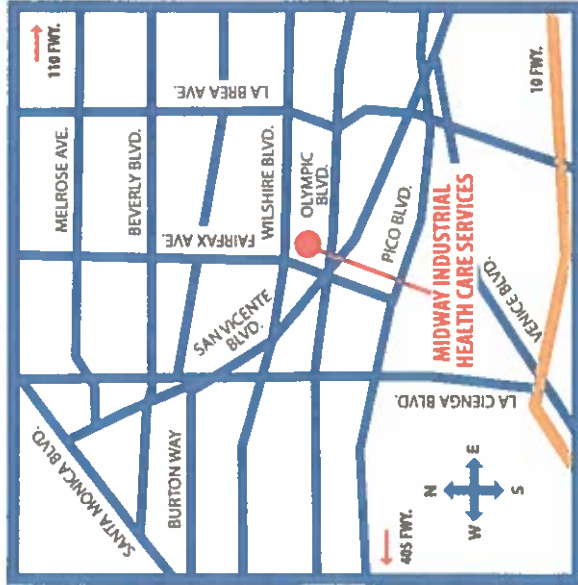
**PLEASE PARK WITH THE VALET AT CORAL TREE CAFÉ
AT THE CORNER OF DARLINGTON AND SAN VICENTE BLVD.
(2 DOORS WEST)**

Midway Industrial Health Care Services

5901 W. Olympic Blvd., Suite 203

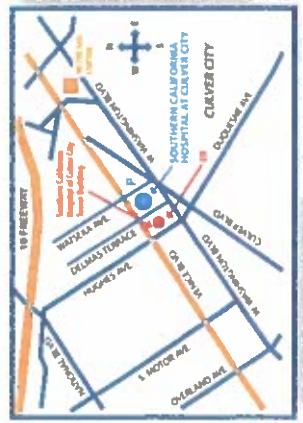
Los Angeles, CA 90036

(323) 930-1331 • After Hours: (310) 202-4745



Hours: 8:30 am to 5:00 pm

After Hours Care: Emergency Room at Southern California Hospital at Culver City



MEDICAL TREATMENT AUTHORIZATION

COMPANY

Company _____

Address _____

Phone Number () _____

EMPLOYEE

Name of Employee _____

Address _____

Phone Number () _____ Date of Birth _____

Social Security Number _____

WORKERS COMPENSATION INSURANCE

Name of Carrier _____

Address _____

Phone Number () _____

APPROVED BY:

Signature _____

Phone Number () _____

Extension _____



3828 Delmas Terrace
Culver City, CA 90232-6806
(310) 836-7000
www.SCH-culvercity.com

(Formerly Brotman Medical Center)

SAMPLE - 5

Workers' Compensation Temporary Prescription ID Card



To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 877.595.3665.

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 Express Scripts, al 877.595.3665.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of \$500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call Express Scripts at 877.595.3665.

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

Express Scripts

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 #: KEENAN1

Employee Date of Birth: ____ / ____ / ____

Please Note: Call Express Scripts with questions at 877.595.3665

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

	M	
First		Last
Street Address or PO Box		
	State	ZIP
City		

Employer Name



Participating Retail Network Pharmacies



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

SANTA MONICA COLLEGE

workers' compensation: Pre-Designation of Personal Physician

If you have health insurance and you are injured on the job you have the right to be treated immediately by your personal physician (M.D., D.O), or medical group, if you notify your employer, in writing, prior to the injury. Per Labor Code 4600 to qualify as the your pre-designated, personal physician, the physician must agree, in writing, to treat you for a work related injury, must have previously directed your medical care and must retain your medical history and records. Your pre-designated physician must be a family practitioner, general practitioner, board certified or board eligible internist, obstetrician-gynecologist or pediatrician. Your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors or medicine or osteopathy, which operates an integrated multi-specialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries.

This is an optional form that can be used to notify your employer of your personal physician. You may choose to use another form, as long as you notify your employer, in writing, prior to being injured on the job and provide written verification that your personal physician meets the above requirements and agrees to be pre-designated. Otherwise, you will be treated by one of your employers' designated workers' compensation medical providers.

EMPLOYEE NAME & ADDRESS:

I acknowledge receipt of this form and elect not to pre-designate my personal physician at this time. I understand that I will receive medical treatment from my employers' medical provider. I understand that, at any time in the future, I can change my mind and provide written notification of my personal physician. I understand that the written notification must be on file prior to an industrial injury.

Employee Signature: _____ Date: _____

If I am injured on the job, I wish to be treated by my personal physician*:

Name of Physician or Medical Group _____ Phone Number _____

Address _____

*This physician is my personal primary care physician who has previously directed my medical care and retains my medical history and records.

Name of Insurance Company, Plan, or Fund providing health coverage for non-occupational injuries or illnesses:

Employee Signature: _____ Date: _____

A Personal Physician must be willing to be pre-designated and treat you for a workers' compensation injury. The remainder of this form is to be completed by your physician and returned to your Employer.

PERSONAL PHYSICIAN ACKNOWLEDGEMENT

Per Labor Code 4600 to qualify you must meet the criteria outlined above. You are not required to sign this form, however, if you or your designated employee, does not sign, other documentation of the physicians' agreement to be pre-designated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

PERSONAL PHYSICIAN OR MEDICAL GROUP NAME: _____

I agree to treat the above named employee in the event of an industrial accident or injury. I meet the criteria outlined above. I agree to adhere to the Administrative Director's Rules and Regulations, Section 9785, regarding the duties of the employee-designated physician.

(Physician or Designated Employee of the Physician or Medical Group)

Date

Please return completed form to:

Risk Management, 1900 Pico Blvd., Santa Monica, CA 90405 -- Fax: (310) 434-3602

**SANTA MONICA COLLEGE
RISK MANAGEMENT DEPARTMENT**

DECLINATION OF WORKERS' COMPENSATION BENEFITS

RE: EMPLOYER: Santa Monica College
EMPLOYEE: _____
DATE OF INJURY: _____
CLAIM NO: _____
OUR FILE NO: _____

I HAVE BEEN ADVISED OF, AND UNDERSTAND, MY RIGHT TO WORKERS' COMPENSATION BENEFITS, WHICH INCLUDE TEMPORARY DISABILITY, PERMANENT DISABILITY AND MEDICAL TREATMENT.

I AM NOT PURSUING WORKERS' COMPENSATION BENEFITS FOR THE INCIDENT WHICH OCCURRED ON _____.
(DATE OF INCIDENT)

I HAVE BEEN OFFERED AN EMPLOYEE'S CLAIM FORM AND I HAVE DECLINED A MEDICAL EVALUATION AND AM HEREBY WAIVING ANY RIGHTS I MAY HAVE TO WORKERS' COMPENSATION BENEFITS FOR THE ABOVE-STATED DATE OF INCIDENT.

Print Name

Signature

Date