Houston Independent School District - Workers' Compensation

EMPLOYEE INJURY AND TREATMENT (EIT) FORM

Please fax to Workers' Compensation at (713) 556-9224 or email to HISDWorkComp@houstonisd.org
If you have any questions, please call: 713-556-9200

Name (Last, First, M.I.)		Gender ◯ F ◯ M
Home Phone Number	Cell Phone Number	Date of Birth
Current Mailing Address (Street or P.O. Box)		
City State Zip Code County		
Injured Employee's Job Title	Employee ID Number	
Does the Employee Speak English? ◯ YES ◯ NO	If No, Specify Language	
Supervisor's Name	Supervisor's Phone Number	
List Witness Name(s), Job Title, and Phone Number		
Did the employee die? ◯ YES ◯ NO	Was employee doing his/her regular job? ◯ YES ◯ NO	

Date of Injury	Time of injury : ◯ am ◯ pm	
Date Reported	Date Lost Time Began	Return to work date
Department or Campus Where Accident or Illness Exposure Occurred		
Where did the injury/illness happen (classroom, hallway, cafeteria, etc.)		
Street Address		
City State Zip Code		
How did the Injury/Illness occur?		
Injured Body Part(s)		

Was the employee transported by ambulance? ◯ YES ◯ NO	*If an ambulance was called, please call either number below:* During business hours, call: 713-556-9200 After hours, call: 713-314-1470
Doctor, Clinic, or Hospital Name and Phone Number	Address of Doctor's Office, Clinic, or Hospital Injured Employee visited

Name and Title of Person Completing Form (*Must be Injured Employee's Supervisor/Nurse*)		Telephone
Business Mailing Address		
City	State	Zip Code

X ______________________________ Date ______________

Supervisor/Nurse that completed form

Do you wish to file for Assault Leave? Please understand that filing for Assault Leave means you must leave the campus and/or location and seek medical treatment for your injury. You cannot return to duty until you are released by your treating doctor. If you do not mark either Yes or No on the EIT form, we will presume that you do not wish to file for assault leave. You must file for assault leave within 30 calendar days from the date of the injury. ◯ **YES** ◯ **NO**

TO WHOM IT MAY CONCERN: (1) I hereby authorize my health care providers to disclose protected health information to Houston ISD (Self-Insured) or its representative for the purpose of verifying, evaluating, and processing my workers' compensation claim. Although this authorization is not needed to obtain my medical records, I voluntarily sign it for the release of all medical, insurance, and billing records to expedite the handling of my claim. I understand that I have the right to revoke this authorization in writing at any time and the right to inspect or copy the information disclosed. This authorization shall expire when my workers' compensation claim ends. (2) I acknowledge I have received information that tells me how to get health care under the HISD WC 504 Provider Panel.

X ______________________________ Date ______________

Injured Employee Signature

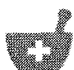
last revised July 2017

Mitchell ScriptAdvisor comp Rx

Workers' Compensation *FIRST FILL* – Temporary Prescription Card

Mitchell ScriptAdvisor has been selected by **CCMSI** 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 **present it at the pharmacy** at the time your prescription is filled. This form should ensure that you will have NO out-of-pocket expenses when you fill your first prescription. Please Note: This is a temporary prescription card, you may receive a permanent drug card in the future.

For your convenience, **Mitchell** ScriptAdvisor has an extensive network of retail pharmacies including major chain drug stores. For pharmacy locations, you may call our toll-free number at 866.846.9279 or visit our website at www.mitchellscriptadvisor.com to access the pharmacy locator.

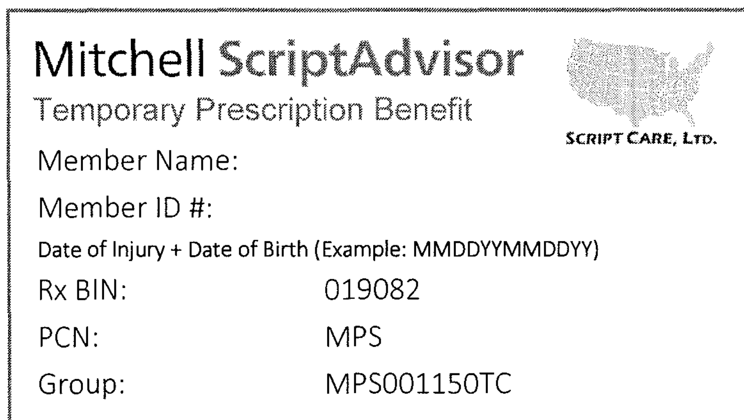


Employee

- You may contact Mitchell Customer Service at (866) 846-9279 or you may present this sheet to the pharmacist along with your prescription.

Pharmacy

- This sheet is a Temporary Prescription ID Card for a 10 Days' Supply Fill until this individual's permanent card can be provided.
- Create the ID number based off the criteria provided and write it, along with individual's name, on the ID card below.
- All data needed to process this script through the Script Care Adjudication System is included in the drug card represented below.



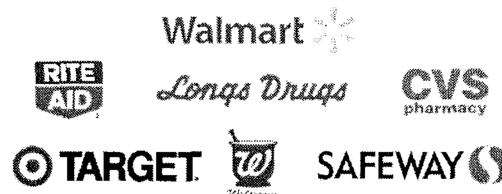
Mitchell ScriptAdvisor
Temporary Prescription Benefit
SCRIPT CARE, LTD.

Member Name:

Member ID #:

Date of Injury + Date of Birth (Example: MMDDYYMMDDYY)

Rx BIN:	019082
PCN:	MPS
Group:	MPS001150TC



Questions?
Contact us at 866.846.9279

This card is to be used for prescriptions related to your workers' compensation injury covered under the workers' compensation insurance policy. Use of this card does not waive any limitations or exclusions for the policy. This card does not confirm coverage. To confirm eligibility or obtain specific information, please contact the Help Desk with the information from the front of this card.

Mitchell Internationa
866.221.658
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