

Lewisville Independent School District
Employee's First Report of Injury or Illness
CALL THE BENEFITS OFFICE THE SAME DAY THE INJURY OCCURS
Phone: 469.948.8071 FAX: 972.350.9360

1. Name (Last, First, M.I.)		2. Sex F <input type="checkbox"/> M <input type="checkbox"/>		15. Date of Injury (m-d-y)	16. Time of Injury	17. Date Lost Time Began (m-d-y)
3. Social Security Number	4. Home Phone		5. Date of Birth (m-d-y)	18. Nature of Injury	19. Part of Body Injured or Exposed	
Employee Number						
6. Does the Employee Speak English? If No, Specify Language YES <input type="checkbox"/> NO <input type="checkbox"/>				20. How and Why Injury/Illness Occurred		
7. Race <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Other		8. Ethnicity Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Native American <input type="checkbox"/>		21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>		22. Worksite Location of Injury (stairs, dock, etc.)
9. Home Mailing Address Street or P.O. Box City State Zip Code County				23. Campus or Facility where injury occurred:		
10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>				24. Cause of Injury (fall, tool, machine, etc.)		
11. Number of Dependent Children		12. Spouse's Name		25. List Witnesses		
13. Will you see a Workers' Comp doctor for this injury? YES <input type="checkbox"/> NO <input type="checkbox"/> Workers' Comp Doctor Name				26. Expected Return to Work Date		27. Supervisor's Name
14. Workers' Comp Doctor's Mailing Address (Street or P.O.Box) City State Zip Code				28. Injured Employee's Occupation		29. Date Injury Reported
Employee Signature				Supervisor Signature		
Date				Official Title		
LISD E-mail address (if applicable)				DWC-1 sent:		

For Benefits Office Use Only

Date of Hire (m-d-y)	Last Paycheck Amount	Last Paycheck Number of Hours for hourly (auxiliary) employees
Rate of Pay at this Job \$ _____ Hourly \$ _____ Daily	37. Hours per day	

This report must be signed by the employee and your Principal, Director or Supervisor
FAX THIS FORM TO THE BENEFITS OFFICE THE SAME DAY THE INJURY OCCURS

***Lewisville Independent School District
Workers' Compensation
Medical Facility Notification Form***

ATTENTION: Medical Facility

Use this form to authorize treatment of work-related injuries. For questions, please call the HRS/Benefits Department at the LISD Administrative Building at 469-948-8071.

Employee _____, **SSN** _____ has claimed to have sustained a job-related injury/illness. You may provide reasonable, necessary and related medical treatment for the claimed injury or illness. Treatment must be within the Texas Official Disability Guidelines (ODG) for the sustained injury or illness. If the treatment recommended is not within the (ODG), then preauthorization is required. Please note, per §134.501 pharmaceutical services dispensed within the first 7 days are covered and cannot be denied, prorated or reduced.

Please do not request payment from the injured employee. Your services should be billed to the workers' compensation carrier / third party administrator listed below:

*Lewisville ISD Self-Insured
c/o Edwards Claims Administration
1004 Marble Heights Drive
Marble Falls, TX 78654
Phone: 830-693-2728
Fax: 830-693-2729*

Please note: Lewisville ISD does NOT participate in a certified network.

Treatment requiring preauthorization should be sent to the workers' compensation third party administrator's utilization review organization:

*Review Med
Phone: 800-201-1021
Fax: 866-400-7790*

Prior to the injured employee leaving your office, please distribute a DWC-73 (Work Status Report) per Workers' Compensation Rule 129.5.

1. Injured employee at the time of the examination via hand delivery
2. Edwards Claims Administration within 2 working days via fax: 830-693-2729
3. LISD Benefits Office within 2 working days via fax: 972-350-9360

Thank you.

Updated August 2019

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