On The Job Injuries

1. Upon notice of an injury, (verbal, written or otherwise) supervisors shall obtain and employees will complete, a First Report of Injury. Forms are located on BHSSC's website (bhssc.org) and may be obtained from the Business Office. BHSSC has seven (7) days to submit a First Report of Injury to our Insurance Company, therefore completed; original forms must be submitted to the main office *within* three (3) days of the injury.

2. Employees can direct specific questions regarding their claim to West River Insurance. West River Insurance may contact the supervisor, employee and any witness involved in a workers compensation claim.

   West River Insurance
   PO Box 13369
   Springfield, IL 62791
   Fax: 217-726-6943
   Phone: 1-866-263-7400 – please reference company name and policy number below

   Company Name on Policy: BH Special Services
   Policy Number: WCMRIC100156102

3. ReliaMax may request timesheets for documentation on claims. Any time missed from work due to a workers compensation claim should be documented by the employee. Workers Compensation payment is not made for lost work time unless an employee is incapacitated for seven (7) consecutive days.

GENERAL INSTRUCTIONS

EMPLOYEE

1. Notify employer immediately of injury, as required by SDCL 62-7-10.
2. Complete all questions in the EMPLOYEE and INJURY/TREATMENT sections.
3. Sign the form.
4. Submit this form to your employer within three (3) business days after the injury.

South Dakota Employer's First Report of Injury

EMPLOYEE

SSN:_____ Date of Birth:_____ Gender: ☐M ☐F Dependents:_____

Name: (Last)_____ (First)_____ (Middle Initial)_____

Mailing Address:_____

City:_____ State:_____ Zip:_____ Telephone No.:_____

Employee Signature: (X)_____ Date:_____

Education: Check One

☐ Less than High School

☐ GED or High School

☐ Beyond High School

INJURY/TREATMENT

Date of Injury:_____ Time of Injury:_____☐am ☐pm Fatality Date (if applicable)_____

County Where Injury Occurred:_____ Was Safety Equipment Provided: ☐ yes ☐ no

Time Work Day Began on Date of Injury:_____☐am ☐pm Was Safety Equipment Used: ☐ yes ☐ no

Date Returned to Work (if applicable):_____ Did Injury Occur on Employer Premises? ☐yes ☐ no

Address or Location of Injury:_____

Description of Injury – What happened to cause injury?_____

_____

Date Employer Notified of Injury:_____

Injury Reported to:_____ Witness:_____

(See all dropdown boxes)

Body Part Injured _____

00

00

00

Nature of Injury (use dropdown box)

00 Not Applicable

Cause of Injury (use dropdown box)

00

Type of Treatment (use dropdown box)

No Treatment

Doctor, Clinic or Hospital Name:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Telephone No. :_____

EMPLOYER/EMPLOYMENT INFORMATION

Federal ID No.: 46361575 # of Employees 500+
Black Hills Special Services Cooperative (BHSSC)
PO Box 218, Sturgis, SD 57785
Telephone 605-347-4467
County Where Employer Located: Meade County

Employment Type: ☐ Regular ☐ Temporary
Employment Status: FT
Date Employee Hired:_____
Employee's Position:_____
Employee's time in Current Position:_____
Employee's Hours Per Week:_____
Employee's Current Wage: $_____

CLAIM OFFICE INFORMATION

NAICS for Employer Being Insured (Nature of Business):

Carrier Code FEIN (Claim Office)

Claim Office

Claim Office Address

City State Zip Code

Telephone

Email Address

Claim Office Claim #

Date Notified Date to DOL

Check if Claim Office is same as Insurance Provider
If not, you must complete the following
UNDERLYING INSURANCE PROVIDER INFORMAITON

Carrier Code (If applicable) FEIN (Insurance Provider)

Represented Entity Name

Address

City State Zip Code

Policy Number

Effective Dates

Adjuster / Contact Person

GENERAL INSTRUCTIONS

EMPLOYEE

5. Notify employer immediately of injury, as required by SDCL 62-7-10.
6. Complete all questions in the EMPLOYEE and INJURY/TREATMENT sections.
7. Sign the form.
8. Submit this form to your employer within three (3) business days after the injury.

BODY PART CODES – on dropdown lists

02	Blindness one eye	44	Chest, including ribs sternum, soft ribs	78	Ring finger at metacarpal bone
03	Blindness both eyes	48	Internal organs-other than heart, lungs	79	Ring finger at proximal joint
04	Deafness both ears	49	Heart	80	Ring finger at middle joint
05	Deafness one ear	51	Hip	81	Ring finger at distal joint
10	Multiple head injury	52	Upper leg	82	Little finger at metacarpal bone
11	Skull	53	Knee	83	Little finger at proximal joint
12	Brain	54	Lower leg	84	Little finger at middle joint
13	Ear(s)	55	Ankle	85	Little finger at distal joint
14	Eye(s)	56	Foot	86	Great toe metatarsal bone
17	Mouth	57	Toe (other than greater)	87	Great toe at proximal joint
19	Face (facial bones)	58	Toe (greater)	88	Great toe at distal joint
20	Multiple neck injury	60	Lungs	90	Multiple injury
21	Vertebrae	61	Groin	92	Other toe metatarsal bone
22	Disc	67	Thumb metacarpal bone	93	Other toe at proximal joint
24	Other	68	Thumb at proximal joint	94	Other toe at middle joint
31	Upper arm	69	Thumb at distal joint	95	Other toe at distal joint
32	Elbow	70	Index finger at metacarpal bone	96	Little toe metatarsal bone
33	Lower Arm-forearm	71	Index finger at proximal joint	97	Little toe at distal joint
34	Wrist	72	Index finger at middle joint		
35	Hand	73	Index finger at distal joint		
37	Thumb	74	Middle finger at metacarpal bone		
38	Shoulder	75	Middle finger at proximal joint		
41	Upper Back	76	Middle finger at middle joint		
42	Lower Back	77	Middle finger at distal joint		

Cause of Injury Codes			
01	Body reaction/over reaction (includes chemicals)	70	Striking against or stepping on
03	Temperature extremes	78	Struck or injured by moving parts of machine
13	Caught in/under/between	81	Struck or injured, includes knife or sharp object, kicked, bit, etc. – struck by object, worker, patient, etc.
25	Fall from elevation	89	Hostile attack-person in act of crime
29	Fall from same level	90	Other than physical cause of injury
50	Motor vehicle	94	Repetitive motion – callous, blister, etc.
56	Bending/Lifting	97	Repetitive motion-carpal tunnel syndrome, etc.
65	Machinery/Equipment	99	Other

Nature of injury codes

00	Not applicable
01	Allergy
02	Disfigurement
71	Occupational disease
72	Hearing loss

Injured Worker First Fill Prescription Form

Instructions for: Employer*

Please complete this form before providing to Injured Worker.

*Last Name, First Name:	*Social Security Number:
*Date of Injury:	*Date of Birth:
*Employer Name: Black Hills Special Services Coop.	

*Required Information

Instructions for: Injured Workers*

To fill your initial (first) prescriptions for a workers' compensation injury, follow these easy steps:

1. Present this form within 15 days of the date you were injured.
2. Locate a participating pharmacy closest to you. For assistance use the following tools:
   - Call: 1.800.758.5779
   - Visit: www.healthesystems.com/pharmacysearch
   - A sample listing of pharmacies are provided at the bottom of this form

*For new injuries only

Instructions for: Pharmacists

Your pharmacy has contracted to participate in the Healthesystems Pharmacy Network. To dispense the patient's first-fill for their workers' compensation prescription:

- Indicate that this is a new workers' comp injury; do not process under an existing injury
- Call the Healthesystems Customer Service Center: 1.800.758.5779
- Process using the Member ID # provided by Healthesystems

Prescription Processing Information:

Transmit prescription using the following

Healthesystems Customer Service Center phone number: 1.800.758.5779 (press 1 for retail pharmacy option)		
BIN: 012874	Carrier/Customer ID: Midwest	* Member ID: *(provided by Healthesystems CSC representative)*

*Required Information

Healthesystems Pharmacy Network

Albertson's	Fred's Pharmacy	Long's Drug Store	Sam's Club	Wal-Mart
Bi-Lo Pharmacy	Giant Eagle	Medicap Pharmacy	Sav-On Drugs	Winn Dixie Pharmacy
Brooks Pharmacy	Giant Pharmacy	Meijer Pharmacy	Shoprite Pharmacy	
Costco Pharmacy	HEB Pharmacy	Osco Drug	Stop & Shop	
CVS Pharmacy	Fred's Pharmacy	Publix Pharmacy	Target	
Duane Reade	Kmart	Rite Aid	Vons Pharmacy	
Eckerd Drug	Kroger Pharmacy	Safeway Pharmacy	Walgreens	

Call 1.800.758.5779 or visit www.healthesystems.com to see a full list of network pharmacies.

The injured worker, in many states, has the free, full and absolute choice in the selection of a pharmacy or pharmacist. The above information is provided if the injured worker needs assistance in locating a pharmacy.