CHECK LIST FOR NEW FOLDERS

- [ ] Prepare lost time chart
- [ ] Acceptance Letter
- [ ] Contact injured employee for statement by telephone (date 05/17/10)
- [ ] Employer initial status of claim (date 05/17/10)
  - [ ] Wage statement
  - [ ] Request for Paid Leave
  - [ ] Supplemental
  - [ ] Request emailed on _____
- [ ] Initial questionnaire to Claimant
- [ ] Work status tracking log
- [ ] Copy of work status to employer
- [ ] Update work status in Allegro
- [ ] Update claim notes for extent of injury & controverted
- [ ] PLN ☐1 _____ ☐2 _____ ☐6 _____ ☐11 _____
- [ ] EDI 1st report Did Salary Continue? Y or N _____
- [ ] DWC Record Check
- [ ] Request witness statement
- [ ] COMP Divider
- [ ] Diary
  - [ ] PLN 11 (define extent of injury within first 60 days)
  - [ ] 8th day, elimination week, 26 weeks, & FMLA ends

Subrogated claim:

- [ ] Notice to claimant
- [ ] Notice to 3rd party
- [ ] Notice to 3rd party insurance
- [ ] Request accident report

Work status change:

- [ ] Update lost time in Allegro
- [ ] Update work status tracking log
- [ ] Copy of work status to Employer

Impairment benefits:

- [ ] PLN 3
- [ ] Update Allegro MMI/IR
- [ ] Subsequent Status Claim Form to Employer
- [ ] Request Wage Statement

Revised 7.05

INITIAL RESERVES
MEDICAL _____
INDEMNITY _____
LAE _____

LOST TIME Y/N ADJUSTER KB npensation,

CLAIM # _____

CARRIER'S CLAIM # 210-0376-23

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex F ☐ M ☑
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y)
6. Does the Employee Speak English? If No, Specify Language: YES ☑ NO ☐
7. Race: White ☐ Black ☐ Asian ☑
8. Ethnicity: Hispanic ☐ Native American ☐ Other ☑
9. Mailing Address: Street or P.O. Box
City / State / Zip Code / County
10. Marital Status: Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
11. Number of Dependent Children: 1
12. Spouse's Name
13. Doctor's Name
14. Doctor's Mailing Address (Street or P.O.Box)
City / State / Zip Code

15. Date of Injury (m-d-y): 05 - 12 - 2010
16. Time of Injury: 10 :00 am ☐ pm ☑
17. Date Lost Time Began (m-d-y): - - NLT
18. Nature of Injury*: Cut w/scapel
19. Part of Body Injured or Exposed*: Left Middle finger
20. How and Why Injury/Illness Occurred*: see attachment
21. Was employee doing his regular job? YES ☑ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*: Laboratory
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site: TAMU Veterinary Medical Park Bldg.
Street or P.O. Box: 1192 Turk Rd. County: Brazos
City: College Station State: TX Zip Code: 77843
24. Cause of Injury(fall, tool, machine, etc.)*: scapel
25. List Witnesses: Helene Andrews-Polymenis; Christine Shields; YI Zheng
26. Return to work date/or expected (m-d-y): - - NLT
27. Did employee die? YES ☐ NO ☑
28. Supervisor's Name: Dr. Helene Andrews-Polymenis
29. Date Reported (m-d-y): 05 - 13 - 2010

RECEIVED MAY 14 2010 AM 10

30. Date of Hire (m-d-y): 12 - 01 - 2009
31. Was employee hired or recruited in Texas? YES ☑ NO ☐
32. Length of Service in Current Position: Months 6 Years _____
33. Length of Service in Occupation: Months 6 Years 3
34. Employee Payroll Classification Code: 7360
35. Occupation of Injured Worker: Postdoctoral Research Associate
36. Rate of Pay at this Job: $_____ Hourly $2833.33 Weekly
37. Full Work Week is: 8 Hours 5 Days
38. Last Paycheck was: $2833.33 for ___ Hours or 30 Days
39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form: Norma Jones, Business Administrator
41. Name of Business: TAMHSC COM Microbial & Molecular Pathogenesis
42. Business Mailing Address and Telephone Number
Street or P.O. Box: 407 Reynolds Medical Bldg. Telephone: (979) 845-1314
City: College Station State: TX Zip Code: 77843
43. Business Location (if different from mailing address) Number and Street
City / State / Zip Code
44. Federal Tax Identification Number: 74-2907553
45. Primary North American Industry Classification System Code:(6 digit) none
46. Specific NAICS Code (6 digit) none
47. Texas Comptroller Taxpayer No. none
48. Workers' Compensation Insurance Company: none
49. Policy Number: self-insured
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☑
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X Norma Jones, Business Admin. Date 5/14/10

DWC FORM-1 (Rev. 10/05) Page 3

DIVISION OF WORKERS' COMPENSATION
5/17/10 Entered

[redacted]

210-0376-23

1st Report of Injury

5/12/2010

A potential exposure to *Salmonella Typhimurium* occurred during a ligated ileal loop surgery on, May 12, 2010. postdoctoral fellow, accidentally cut himself with a scalpel (a very small cut on his finger) during the processing of infected tissue at about 10 pm. He was immediately removed from his station, he removed his PPE (N95, gloves, booties, hairnet) and was sent out of the BSL-2 surgery suite to scrub with chlorhexidine containing surgical scrub for 10 minutes in the scrubbing sinks located immediately outside the surgical suite. After scrubbing the affected area thoroughly, he applied antibiotic cream to the area and a band-aid.

[redacted]

210-0376-23

hr HUMAN RESOURCES

TEXAS A&M UNIVERSITY

Supplemental Witness Statement

Privacy Notice: State law requires that you be informed that you are entitled to: (1) request to be informed about the information collected about yourself on this form (with a few exceptions as provided by law); (2) receive and review that information; and (3) have the information corrected at no charge. To request this information, contact hrcompbenefits@tamu.edu or (979) 862-1718.

INSTRUCTIONS This statement should be complete by a supervisor or willing employee who personally witnessed a work-related injury and sent in with the First Report of Injury or as soon as possible thereafter.

Name of Claimant:	
Name of Individual Providing Statement: Helene Andrews-Polymenis	
Please check one: • Supervisor Employee	
Department Contact: Norma Jones	Phone: 5-1314
Department: MMPA	Mail Stop: 114

The claimant referenced above was possibly involved in a work-related on May 12, 2010 (indicate date) about _____ a.m./p.m. If you have firsthand information, please answer the questions listed below and return this form by fax (979) 847-8546 to the Total Compensation Benefits Office

Describe in your own words what happened and what you observed. Be as specific as possible.

Claimant nicked his finger through double gloves with a disposable scalpel.

Describe what part of the body you observed to be injured.

Middle finger, left hand.

Helene Andrews-Polymenis
Signature of Witness

May 13, 2010
Date

[redacted]

2010 MAY 14 PM 4:30

Supplemental Witness Statement
#585

10-27-09
Page 1 of 1

INITIAL CLAIM QUESTIONNAIRE

KB

Claimant:
Address:

Claim # 210-0376-23
Date of Injury: 05/12/2010
Date mailed: 05/18/2010

Please complete, sign, and date this claims questionnaire and return in the enclosed postage paid envelope as soon as possible.

RECEIVED
2010 MAY 24 AM 10:36
TAMUS OFFICE OF RISK MANAGEMENT

1. Did your injury occur while performing your normal job duties?

Yes.

2. Please state in your own words where and how your injury occurred.

It happened in the calf surgeon room in Veternary medical park. I accidently pinch my left hand middle finger by a scalpel that I ~~was~~ using for processing the intestine loop just cut off from calf.

3. Please state in your own words any physical harm or damage to your body that resulted from the work related incident.

When it happened, my finger started bleeding, then we stop right away, removed the double glove, washed it for about 10 minute, put on antibiotic ointment. I was back to work. Next day, I did not ~~felt feel any~~ feel any uncomfortable

4. Have you sought medical attention for this injury? If so please indicate your choice of primary care physician. Have you seen this physician in the past three years for other conditions whether work related or not. No Frankly, no. since I didnot have any symptom. And, no, I didnot see the physician in the past three years for conditions ~~not~~ that work related.

5. If you have multiple employers please list the name and address of each employer

I am the employer of tamksc, which is the only one right now

Injured employee signature

5/20/10
Date

c:inques

210-0376-23

Ball, Kaye

From: Pantusa, Victor [vpantusa@tamhsc.edu]
Sent: Friday, May 14, 2010 2:30 PM
To: Ball, Kaye
Subject: FW: 1st Report of Injury-
Attachments: 1st Report of

Kaye,
Please see attached first report of injury, sharps report and witness report for

Thanks,
Victor

RECEIVED
2010 MAY 14 PM 4:30
TAMUS
OFFICE OF RISK MANAGEMENT

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Fax 979-458-6247 • http://tamusystem.tamu.edu

May 17, 2010

Dear

This office is in receipt of a First Report of Injury indicating that you sustained a work-related injury on 05/12/2010.

Any medical bills you incur as a direct result of this injury should be immediately forwarded to this office for consideration. Prescription drugs may be filled at any pharmacy. Please do not use your health care insurance to have these prescriptions filled.

If you miss more than a day of work as result of this injury you must contact your department to ensure that you receive all the benefits to which you may be entitled.

If you have any questions regarding your claim, please come by our office or call us at (979) 458-6330.

Sincerely,

Kaye Ball

KAYE BALL
Workers' Compensation Insurance
Risk Management Division

Enclosure

THE TEXAS A&M UNIVERSITY SYSTEM

Kaye Ball
WCI Claims Adjuster
Risk Management

A&M System Building
200 Technology Way, Suite 1120
Mail Stop 1262 TAMU
College Station, Texas 77845-3424
kball@tamu.edu
www.tamus.edu

979.458.6330
979.458.6247 fax

MEDICAL SERVICES CHART

CLAIM# 210-0376-23

CLAIMANT

DOI: 5/9/10 Nature of Injury Laceration/Exposure Possible

Body Part Injured Lt. Middle Finger

Treating Dr

Approved Change

Consulting/Referral (approval date)

RME Date

Result

D/D Date

Result

Accepted diagnosis

Initial Treatment Plan

Secondary Treatment Plan or Changes

X-Ray
Body Part Date Result

MRI
Body Part Date Result

C/T Scan
Body Part Date Result

Bone Scan
Body Part Date Result

Myelogram
Body Part Date Result

EMG
Body Part Date Result

PHYSICAL THERAPY

WEEK 1	WEEK 1
WEEK 2	WEEK 2
WEEK 3	WEEK 3
WEEK 4	WEEK 4
WEEK 5	WEEK 5
WEEK 6	WEEK 6
WEEK 7	WEEK 7
WEEK 8	WEEK 8

COMMENTS:

SURGICAL PROCEDURES

Date
Date
Date
Date
Date

DENIED MEDICATIONS

PREAUTHORIZATIONS

DATE	YES/NO	PROCEDURE

BODY PART DENIED
DATE PLN 1 FILED Y/N
BODY PART DENIED
DATE PLN 1 FILED Y/N
BODY PART DENIED
DATE PLN 1 FILED Y/N
NOTES:

INITIAL CLAIM QUESTIONNAIRE

Claimant:
Address

Claim # 210-0376-23
Date of Injury: 05/12/2010
Date mailed: 05/18/2010

Please complete, sign, and date this claims questionnaire and return in the enclosed postage paid envelope as soon as possible.

1. Did your injury occur while performing your normal job duties?

2. Please state in your own words where and how your injury occurred.

3. Please state in your own words any physical harm or damage to your body that resulted from the work related incident.

Reeld
5/24/10

4. Have you sought medical attention for this injury? If so please indicate your choice of primary care physician. Have you seen this physician in the past three years for other conditions whether work related or not.

5. If you have multiple employers please list the name and address of each employer

Injured employee signature

Date

c inques

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Fax 979-458-6247 • http://tamusystem.tamu.edu

May 18, 2010

Brazos County Health District
ATTN: Ken E Bost
201 North Texas Ave.
Bryan, TX 77803

RE: Title 25 Health Services, Chapter 96 Bloodborne Pathogen Control

Please find attached a Contaminated Sharps Injury Reporting Form for May, 2010, from The Texas A&M University System, Texas A&M University Health Science Center.

Should you have any questions please feel free to contact me as the reporting officer.

Sincerely,

Deanna Holladay /dr

Deanna Holladay
WCI Manager

Enclosure

TEXAS Department of State Health Services

210-0376-23

INFECTIOUS DISEASE CONTROL

CONTAMINATED SHARPS INJURY REPORTING FORM

The facility where the injury occurred should complete the form and submit it to the local health authority where the facility is located. If no local health authority is appointed for this jurisdiction, submit to the regional director of the Texas Department of State Health Services (DSHS) regional office in which the facility is located. Address information for regional directors can be obtained on the DSHS webpage at http://www.dshs.state.tx.us/regions/default.shtm. The local health authority, acting as an agent for the Texas Department of State Health Services will receive and review the report for completeness, and submit the report to: IDEAS, Texas DSHS, 1100 West 49th Street, T-801, Austin, Texas 78756-3199. Obtain copies at http://www.dshs.state.tx.us/idcu/health/infection_control/bloodborne_pathogens/reporting or from Texas Department of State Health Services regional offices.

Please complete a form for each exposure incident involving a sharp.

NOTE: If the injury occurred BEFORE the sharp was used for its original intended purpose, *do not* submit this form

Facility (agency/institution) **where injury occurred:** TAMU Veterinary Medical Park Rm Bldg		
Street address (no post office box): 1192 Turk Rd.		
City: College Station	**County:** Brazos	**Zip code:** 77843
Street address of reporter if different from facility where injury occurred: Reynolds Med. Bldg. TAMU		
Date: 5/14/10	**Reporter's Name:** Helene Andreus-Polymenis	
	Reporter's Telephone: 979-845-9438	**Reporter's e-mail:** handreus@medicine.tamhsc.edu
3. Date of Injury: 5/13/10 Time of Injury: 10 [illegible] Age of Injured: 39 Sex of Injured: F [illegible]		
4. Type and Brand of Device Involved in Injury: Unknown		

Needles

- ☐ Arterial catheter introducer needle
- ☐ Blood gas syringe
- ☐ Central line catheter needle (cardiac, etc.)

Disposable Syringe

- ☐ Insulin
- ☐ 20-gauge needle
- ☐ 21-gauge needle
- ☐ 22-gauge needle
- ☐ 23-gauge needle
- ☐ 24/25-gauge needle
- ☐ Tuberculin

- ☐ Drum catheter needle
- ☐ IV catheter stylet
- ☐ Needle on IV line (includes piggybacks & IV line connectors
- ☐ Needle, not sure what kind
- ☐ Pre-filled cartridge syringe
- ☐ Spinal or epidural needle
- ☐ Suture needle
- ☐ Syringe, other type
- ☐ Unattached hypodermic needle
- ☐ Vacuum tube blood collection holder/needle
- ☐ Winged steel needle (includes butterfly, winged-set type devices)

Other

- ☐ Other vascular catheter needle (cardiac, etc.)
- ☐ Other non-vascular catheter needle (ophthalmology, etc.)
- ☐ Other nonsuture _____

Surgical Instruments *(or other sharp items)*

- ☐ Bone chip/chipped tooth
- ☐ Bone cutter
- ☐ Drill bit/bur
- ☐ Electro-cautery device
- ☐ Fingernails/teeth
- ☐ Huber needle
- ☐ Lancet (finger or heel stick)
- ☐ Microtome blade
- ☐ Pickups/forceps/ hemostats/clamps
- ☐ Pin (fixation, guide pin)
- ☐ Pipette (plastic)
- ☐ Razor
- ☐ Retractors, skin/bone hooks
- ☒ Scalpel, disposable
- ☐ Scalpel, reusable
- ☐ Scissors
- ☐ Sharp item, not sure what kind
- ☐ Specimen/test tube (plastic)
- ☐ Staples/steel sutures
- ☐ Towel clip
- ☐ Trocar
- ☐ Vacuum tube (plastic)
- ☐ Wire (suture/fixation/guide wire)
- ☐ Other sharp _____

Glass

- ☐ Capillary tube
- ☐ Glass slide
- ☐ Glass item, not sure what kind
- ☐ Medication ampule/vial/IV bottle
- ☐ Pipette
- ☐ Specimen/test tube
- ☐ Vacuum tube
- ☐ Other glass item

MAY 14 PM 4:30

8/26/2009

[redacted]

210-0376-23

3. Original intended use of sharp (*check one box*)

- ☐ Connect IV line (intermittent IV/piggyback/IV infusion/other IV line connection
- ☐ Contain a specimen or pharmaceutical (glass item)
- ☒ Cutting
- ☐ Dental ☐ Extraction ☐ Hygiene ☐ Orthodontic ☐ Periodontal ☐ Restorative ☐ Root Canal
- ☐ Dialysis
- ☐ Draw arterial blood sample...*If used to draw blood was it* ☐ direct stick *or* ☐ drawn from a line
- ☐ Draw venous blood sample
- ☐ Drilling
- ☐ Electrocautery
- ☐ Finger Stick/heel stick
- ☐ Heparin or saline flush
- ☐ Injection, intra-muscular/subcutaneous/intra-dermal, or other injection through the skin (syringe)
- ☐ Obtain a body fluid or tissue sample (urine/CSF/amniotic fluid/other fluid, biopsy)
- ☐ Other injection into (or aspiration from) IV injection site or IV port (*syringe*)
- ☐ Remove central line/porta catheter
- ☐ Start IV or set up heparin lock (IV catheter or winged set-type needle)
- ☐ Suturing ☐ deep ☐ skin
- ☐ Tattoo
- ☐ Unknown/not applicable
- ☐ Wiring
- ☐ Other _____

4. When and How Injury Occurred...

☐ Before (DO NOT report to DSHS) ☒ during ☐ after the sharp was used for its intended purpose

If the exposure occurred during or after the sharp was used, was it (*check one box*)

- ☐ Activating safety device
- ☐ Between steps of a multistep procedure (carrying, handling, passing/receiving syringe/instrument, etc.)
- ☐ Device malfunctioned
- ☐ Device pierced the side of the disposal container
- ☐ Disassembling device or equipment
- ☐ Found in an inappropriate place (eg. Table, bed, linen, floor, trash)
- ☐ Interaction with another person
- ☒ Laboratory procedure/process
- ☐ Patient moved during the procedure
- ☐ Preparation for reuse of instrument (cleaning, sorting, disinfecting, sterilizing, etc.)
- ☐ Recapping
- ☐ Suturing
- ☐ Use of sharps container
- ☐ Unsafe practice
- ☐ Use of IV/central line
- ☐ Other _____

5. Did the device being used have engineered sharps injury protection? ☐ yes ☒ no ☐ do not know

A. Was the protective mechanism activated? ☐ yes ☐ no ☐ do not know NA

B. Did the exposure incident occur: ☐ before ☐ during ☐ after activation of the protective mechanism NA

6. Was the injured person wearing gloves? ☒ yes ☐ no ☐ do not know

7. Had the injured person completed a hepatitis B vaccination series? ☐ yes ☐ no ☒ do not know

8. Was there a sharps container readily available for disposal of the sharp? ☒ yes ☐ no

Did the sharps container provide a clear view of the level of contaminated sharps? ☒ yes ☐ no

9. Had the injured person received training on the exposure control plan in the 12 months prior to the incident? ☒ yes ☐ no

10. Involved body part (*check one box*) ☒ hand ☐ arm ☐ leg/foot ☐ face/head/neck ☐ torso (front or back)

8/26/2009

[redacted]

210-0376-23

11. Job Classification of injured person *(check only one box)*:

- ☐ Aide (e.g. CAN, HHA, orderly)
- ☐ Attending physician (MD, DO)
- ☐ Central supply
- ☐ Chiropractor
- ☐ Clerical/administrative
- ☐ Clinical lab technician
- ☐ Counselor/social worker
- ☐ CRNA/NP
- ☐ Dentist
- ☐ Dental assistant/technician
- ☐ Dental hygienist
- ☐ Dental student
- ☐ Dietician
- ☐ EMT/ paramedic
- ☐ Fellow
- ☐ Firefighter
- ☐ Food service
- ☐ Hemodialysis technician
- ☐ Housekeeper/laundry
- ☐ Intern/resident
- ☐ Law enforcement officer
- ☐ Licensed vocational nurse
- ☐ Maintenance staff
- ☐ Medical student
- ☐ Morgue tech/autopsy tech
- ☐ Nurse midwife
- ☐ Nursing student
- ☐ OR/surgical technician
- ☐ Pharmacist
- ☐ Physician assistant
- ☐ Physical therapist
- ☐ Phlebotomist/venipuncture/IV team
- ☐ Psychiatric technician
- ☐ Public health worker
- ☐ Radiologic technician
- ☐ Registered nurse
- ☒ Researcher
- ☐ Respiratory therapist/technician
- ☐ Safety/security
- ☐ School personnel (not nurse)
- ☐ Transport/messenger
- ☐ Volunteer
- ☐ Other _____

12. Employment Status of Injured Person *(check one box)*:

☒ Employee ☐ Student ☐ Contractor/contract employee ☐ Volunteer ☐ Other

If not directly employed by reporter, name the employer/service/agency/school: _____

13. Location/Facility/Agency in which sharps injury occurred *(check one box)*:

- ☐ Blood bank/center/mobile
- ☐ Clinic
- ☐ Correctional facility
- ☐ Dental facility
- ☐ EMS/Fire/Police
- ☐ Home health
- ☐ Hospital
- ☒ Laboratory (freestanding)
- ☐ Medical examiner office/morgue
- ☐ Outpatient treatment (e.g. dialysis, infusion therapy)
- ☐ Residential facility (e.g. MHMR, shelter)
- ☐ School/college
- ☐ Other _____

14. Work Area where Sharps Injury Occurred *(check one box)*:

- ☐ Ambulance
- ☐ Autopsy/pathology
- ☐ Blood bank center/mobile
- ☐ Central supply
- ☐ Critical care unit
- ☐ Dental clinic
- ☐ Dialysis room/center
- ☐ Emergency department
- ☐ Endoscopy/bronchoscopy/ cystoscopy
- ☐ Field (non EMS)
- ☐ Floor (not patient room)
- ☐ Home
- ☐ Infirmary
- ☐ Jail unit
- ☐ Laboratory
- ☐ L & D/Gynecology unit
- ☐ Medical/Outpatient clinic
- ☒ Medical/surgical unit
- ☐ Nursery
- ☐ Patient/resident room
- ☐ Pediatrics
- ☐ Pre-op or PACU
- ☐ Procedure room
- ☐ Rescue setting (non ER)
- ☐ Radiology department
- ☐ Seclusion room/psychiatric unit
- ☐ Service/Utility area (e.g. laundry)
- ☐ Surgery/operating room
- ☐ Other _____

COMMENTS:

FILED 2010 Nov 14 PM 4:30

FILED 2010 Nov 14 PM 4:30

CHECK LIST FOR NEW FOLDERS

- ☐ Prepare lost time chart
- ☐ Acceptance Letter
- ☑ Contact injured employee for statement by telephone (date 08/10/10)
- ☑ Employer initial status of claim (date 08/10/10)
  - ☐ Wage statement
  - ☐ Request for Paid Leave
  - ☐ Supplemental
  - ☑ Request emailed on _____
- ☑ Initial questionnaire to Claimant
- ☐ Work status tracking log
- ☐ Copy of work status to employer
- ☐ Update work status in Allegro
- ☑ Update claim notes for extent of injury & controverted
- ☐ PLN ☐1 _____ ☐2 _____ ☐6 _____ ☐11 _____
- ☐ EDI 1st report Did Salary Continue? Y or N _____
- ☐ DWC Record Check
- ☐ Request witness statement
- ☐ COMP Divider
- ☑ Diary
  - ☐ PLN 11 (define extent of injury within first 60 days)
  - ☐ 8th day, elimination week, 26 weeks, & FMLA ends

Subrogated claim:

- ☐ Notice to claimant
- ☐ Notice to 3rd party
- ☐ Notice to 3rd party insurance
- ☐ Request accident report

Work status change:

- ☐ Update lost time in Allegro
- ☐ Update work status tracking log
- ☐ Copy of work status to Employer

Impairment benefits:

- ☐ PLN 3
- ☐ Update Allegro MMI/IR
- ☐ Subsequent Status Claim Form to Employer
- ☐ Request Wage Statement

Revised 7 05

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Toll Free: 866-249-8574 • Fax 979-458-6247 • http://tamusystem.tamu.edu

NOTICE OF DENIAL OF COMPENSABILITY/LIABILITY AND REFUSAL TO PAY BENEFITS

DATE: August 10, 2010

TO: NAME OF INJURED EMPLOYEE:
ADDRESS:
CITY, STATE, ZIP:

FAXED TO STARR
DATE: 8/10/10 AL

RE: DATE OF INJURY: 08/03/2010
NATURE OF INJURY: Potential Exposure to Brucella
PART OF BODY INJURED: Respiratory System
EMPLOYEE SSN:
DWC #: Unassigned
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 210-0536-02
EMPLOYER NAME: Texas A&M University
EMPLOYER ADDRESS: General Services Complex, Ste 1201
EMPLOYER CITY, STATE, ZIP: College Station, TX 77843

On August 4, 2010 we received notice that you reported an on the job injury. We are denying your claim for workers' compensation benefits. Workers' compensation benefits, including medical benefits, are not being paid because:

The Texas A&M University System as the workers' compensation insurance carrier for the Texas A&M University disputes compensability/liability for the incident that occurred on or about 08/03/2010. Exposure in and of itself would not be considered an injury in course and scope of employment, absent physical harm or damage to the physical structure of the body , nor an occupational disease absent an illness resultant from the exposure. If further evidence is presented, it will be reviewed.

If you do not agree with the denial and refusal to pay benefits, please contact me:

Adjuster's Name: **Kaye Ball**
Toll Free Telephone #: **1-866-249-8574**
Fax #/E-mail Address: **1-979-458-6247/KBall@tamu.edu**

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. Contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

Cc: DWC, 7551 Metro Center Drive, Ste. 100, Austin, Texas 78744-1645

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3976
RECIPIENT ADDRESS	917134624143
DESTINATION ID	
ST. TIME	08/10 14:56
TIME USE	00'26
PAGES SENT	1
RESULT	OK

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Toll Free: 866-249-8574 • Fax 979-458-6247 • http://tamusystem.tamu.edu

NOTICE OF DENIAL OF COMPENSABILITY/LIABILITY AND REFUSAL TO PAY BENEFITS

DATE: August 10, 2010

TO: NAME OF INJURED EMPLOYEE:
ADDRESS:
CITY, STATE, ZIP:

FAXED TO STARR
DATE: 8/10/10 AL

RE: DATE OF INJURY: 08/03/2010
NATURE OF INJURY: Potential Exposure to Brucella
PART OF BODY INJURED: Respiratory System
EMPLOYEE SSN:
DWC #: Unassigned
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 210-0536-02
EMPLOYER NAME: Texas A&M University
EMPLOYER ADDRESS: General Services Complex, Ste 1201
EMPLOYER CITY, STATE, ZIP: College Station, TX 77843

On August 4, 2010 we received notice that you reported an on the job injury. We are denying your claim for workers' compensation benefits. Workers' compensation benefits, including medical benefits, are not being paid because:

The Texas A&M University System as the workers' compensation insurance carrier for the Texas A&M University disputes compensability/liability for the incident that occurred on or about 08/03/2010. Exposure in and of itself would not be considered an injury in course and scope of employment, absent physical harm or damage to the physical structure of the body , nor an occupational disease absent an illness resultant from the exposure. If further evidence is presented, it will be reviewed.

If you do not agree with the denial and refusal to pay benefits, please contact me:

Adjuster's Name: **Kaye Ball**
Toll Free Telephone #: **1-866-249-8574**
Fax #/E-mail Address: **1-979-458-6247/KBall@tamu.edu**

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. Contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this [illegible]

Send the specified copies of:
Work INITIAL RESERVES
and t MEDICAL
*Emp INDEMNITY
Texas LAE
Unless LOST TIME Y/N ADJUSTER KB

ssation,

CLAIM #

CARRIER'S CLAIM # 210-0536-02

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.) DeCanopy
2. Sex F ☑ M ☐
3. Social Security Number 4 -
4. Home Phone
5. Date of Birth (m-d-y)
6. Does the Employee Speak English? If No, Specify Language: YES ☑ NO ☐
7. Race: White ☐ Black ☐ Asian ☑
8. Ethnicity: Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address Street or P.O. Box: #304
10. Marital Status: Married ☐ Widowed ☐ Separated ☐ Single ☑ Divorced ☐
11. Number of Dependent Children: 0
12. Spouse's Name
13. Doctor's Name —
14. Doctor's Mailing Address (Street or P.O.Box): Scott + White
City College Station State TX Zip Code

15. Date of Injury (m-d-y): 08 - 03 - 10
16. Time of Injury: 4 :30 am ☐ pm ☑
17. Date Last Time Be[illegible] an (m-d-y): NLT - -
18. Nature of Injury*: Possible aerosol exposure to biological material.
19. Part of Body Injured or Exposed*: Respiratory
20. How and Why Injury/Illness Occurred*: did not wear respiratory protection in BL3 lab.
21. Was employee doing his regular job? YES ☑ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*: BL3 suite in Bldg 1197
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site: Veterinary Pathobiology
Street or P.O. Box: 4467 TAMU
County: Brazos
City: College Station State: TX Zip Code: 77843
24. Cause of Injury(fall, tool, machine, etc.)*: Possible respiratory exposure due to failure of wearing protective gear.
25. List Witnesses: Yaping Fan and Gabrial Gomez
26. Return to work date/or expected (m-d-y): 08 - 04 - 10
27. Did employee die? YES ☐ NO ☑
28. Supervisor's Name: Dr. Thomas Ficht
29. Date Reported (m-d-y): 08 - 04 - 10

30. Date of Hire (m-d-y): 07 - 08 - 2009
31. Was employee hired or recruited in Texas? YES ☑ NO ☐
32. Length of Service in Current Position: Months 8 Years —
33. Length of Service in Occupation: Months — Years 1
34. Employee Payroll Classification Code: 5005
35. Occupation of Injured Worker: Technician I
36. Rate of Pay at this Job: $ 12.80 Hourly $ — Weekly
37. Full Work Week is: 40 Hours — Days
38. Last Paycheck was: $ 1024 for 80 Hours or — Days
39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form: Jeanine Malazzo
41. Name of Business: Texas A&M University
42. Business Mailing Address and Telephone Number
Street or P.O. Box: Veterinary Pathobiology; 4467 TAMU
Telephone: (979) 845-5944
City: College Station State: TX Zip Code: 77843
43. Business Location (if different from mailing address)
Number and Street: TAMU Human Resources; 1255 TAMU
City: College Station State: TX Zip Code: 77843
44. Federal Tax Identification Number: 74-6000-531
45. Primary North American Industry Classification System Code:(6 digit)
46. Specific NAICS Code (6 digit)
47. Texas Comptroller Taxpayer No
48. Workers' Compensation Insurance Company: The Texas A&M University System-Self Insuranc
49. Policy Number: Self-Insured
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X Jeanine Malazzo Business Coord I Date 8-4-10

Entered NF

DIVISION OF WORKERS' COMPENSATION

SUPPLEMENT FOR OCCUPATIONAL DISEASE

SUPERVISOR'S STATEMENT **CLAIM # 210-0536-02** KB

Injured Employee:
Social Security Number:
Date of Injury: 8/10/10
(date knew or should have known of injury)

Location (area) employee was working when injury occurred: Employee was working in room (biosafety level 3 suite) in building 1197

Body Part Injured: due to accidental failure to don respirator employee may have inhaled infectious agent Brucella spp. Right vs. left does not apply
(please indicate if right or left applies)

Describe symptoms and dates reported by employee for this injury: the employee was seen by the occupational health physician at Scott & White who prescribed appropriate antibiotics and serological monitoring for infection which can take several weeks to observe.

List any person you feel may have knowledge to support this claim for compensation: The employees co-workers Yaping Fan and Gabriel Gomez were in room at the time of the incident.

Please indicate number of job tasks routinely required which may be related to an occupational exposure injury: personnel work in the BSL3 laboratory continuously and are required to receive training from the university and the individual investigators. Ordinarily all manipulations of infectious agent are performed within biological safety cabinets. The work being done was also contained within the BSC, as such the risk of infection was low. Respiratory protection is worn to prevent against infection in the case of spills or other accidents.

Signature: Thomas Fickel

Date: 8/10/10

RETURN AS SOON AS POSSIBLE TO:

THE TEXAS A&M UNIVERSITY SYSTEM
OFFICE OF THE TREASURER
200 TECHNOLOGY WAY, SUITE 1120
COLLEGE STATION, TEXAS 77845-3424
Fax 979-458-6247

RECEIVED
2010 AUG 11 AM 8:25
TAMUS
OFFICE OF RISK MANAGEMENT

210 - 0536-02K

The Texas A&M University Position Description

The Position Description form is used to record the duties, responsibilities, qualifications sought and fiscal impact of classified and nonclassified staff positions. This information is the basis for determining the title, salary rate, and Fair Labor Standards Act exemption status for staff positions. To achieve these purposes, it is essential that detailed and exact information pertaining to current duties, responsibilities, and qualifications be accurately recorded on this form. Please attach a current organizational chart when submitting this form.

Employee Details

Employee First Name:	
Employee Last Name:	
Employee UIN	

Position Title

Position Title	Technician I
Title Code	5005
Classified / Non-Classified	Classified

Position Information

TAMU System Member	TAMU
Location	College Station
Department	Vet Med Pathobiology-02-144006
Direct Supervisor Click for additional directions.	Ficht, Thomas A.
Other Users Authorized to Access Position Description Click for additional directions.	Suehs, Betty L. Malazzo, Jeanine Vychopen, Patty
Employee User Account for Position Description Click for additional directions.	
PIN	M36045
ADLOC Account	02-144006
FLSA	Non-exempt
Funding Account(s) If more than one funding account, please indicate percentage for each.	06-502304
Primary Funding Source	Restricted
If 'Other' Primary Funding Source, Please Specify:	

RECEIVED
2010 AUG 11 AM 8:25
TAMUS
OFFICE OF RISK MANAGEMENT

210-0536-02KB

Duration of Position	Regular/budgeted - FT
If 'Part Time', Please Specify Percent Effort:	
Security Sensitive?	
(Employment in all positions are security sensitive and will be contingent on the results of a criminal background check at the point of hire. Please click here for additional information.)	Yes
Is this position restricted by the Patriot Act? (For details click here)	No
Is this position D.O.T. regulated? (For details click here)	No
Secondary Costs: Click for additional directions. If no secondary costs, indicate "none."	None
Employees Supervised: Include titles and number of each. If position will not supervise anyone at this time, please state "none."	None
Does this employee customarily and regularly exercise **discretion and independent judgment** and have the authority to make important decisions? Click for additional directions.	No
If Yes, give percentage:	
Please indicate machines or equipment used in the performance of essential duties: (It is required that you include hours during an average week that each piece of equipment is actually used. For most positions the combined total usage will seldom approach 40 hours.) Click for additional directions.	Personal Computer - 15 hrs Centrifuge - 3 hrs
Required Education and Experience Click for additional directions.	Bachelor's degree in a related field or any equivalent combination of training and experience.
Preferred Education and Experience Click for additional directions.	One year in scientific research, clinical, operational, or experimental work.
Required licenses, certifications, or registrations: Click for additional directions.	None
Preferred licenses, certifications, or registrations: Click for additional directions.	
Required special knowledge, abilities, and skills: Click for additional directions.	None
Preferred special knowledge, abilities, and skills: Click for additional directions.	
Other requirements or other factors: Click for additional directions.	Ability to multi-task and work cooperatively with others.
Preferred other requirements or other	

210-0536-02
KB

factors: Click for additional directions.	None
General Summary: Summarize in three or four sentences the general purpose, scope and responsibilities of this position Click for additional directions.	Assists in planning research on support laboratory methods and techniques, carrying out procedures, and recording results for a series of closely-controlled experiments.

Job Duties

Total Percentage of Duties:**100**

5 Records

Essential?	Duty Title	Duties	% of Time
Yes		Plan and participate in the execution of experiments in cell biology, maintenance of cell lines and stock of commonly used reagents. Research literature relevant to research subject.	40
Yes		Use standardize assays and technical procedures.	30
Yes		Assists in maintaining the laboratory including, but not limited to, ordering supplies, record keeping, the maintenance and service of equipment, inventory, data entry and some data analysis	19
Yes		Participate in regular laboratory meetings and technical discussions.	10
No		Other duties as assigned	1

Date	*Signature of Employee*	
Date	*Signature of Immediate Supervisor*	*Title*
Date	*Signature of Department Head or Comparable Unit*	*Title*
Date	*Signature of Vice President, Dean or Director*	*Title*

RECEIVED
2010 AUG 11 AM 8:25
TAMUS
OFFICE OF RISK MANAGEMENT

215-0536-02

Coffer, Lisa

From: Kuhlmann, Jim R.
Sent: Wednesday, August 04, 2010 2:19 PM
To: WCI Incoming EMail
Subject:
Attachments: - Vet Pathobiology.pdf

This claimant has received medical attention.

Jim R. Kuhlmann
Leave Specialist
Human Resources
Texas A&M University
jkuhlmann@tamu.edu

1255 TAMU | College Station, TX 77843-1255
Tel. 979.862.4971| Fax 979.847.8546
http://employees.tamu.edu

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Fax 979-458-6247 • http://tamusystem.tamu.edu

August 04, 2010

This office is in receipt of a First Report of Injury indicating that you sustained a work-related injury on 08/03/2010.

Any medical bills you incur as a direct result of this injury should be immediately forwarded to this office for consideration. Prescription drugs may be filled at any pharmacy. Please do not use your health care insurance to have these prescriptions filled.

If you miss more than a day of work as result of this injury you must contact your department to ensure that you receive all the benefits to which you may be entitled.

If you have any questions regarding your claim, please come by our office or call us at (979) 458-6330.

Sincerely,

KAYE BALL
Workers' Compensation Insurance
Risk Management Division

Enclosure

MEDICAL SERVICES CHART

CLAIM# 210-0536-02

CLAIMANT

DOI: 8/3/10 Nature of Injury Possible Exposure to Brucella

Body Part Injured Respiratory

Treating Dr

Approved Change

Consulting/Referral (approval date)

RME Date

Result

D/D Date

Result

Accepted diagnosis

Initial Treatment Plan

Secondary Treatment Plan or Changes

X-Ray
Body Part Date Result

MRI
Body Part Date Result

C/T Scan
Body Part Date Result

Bone Scan
Body Part Date Result

Myelogram
Body Part Date Result

EMG
Body Part Date Result

PHYSICAL THERAPY

WEEK 1	WEEK 1
WEEK 2	WEEK 2
WEEK 3	WEEK 3
WEEK 4	WEEK 4
WEEK 5	WEEK 5
WEEK 6	WEEK 6
WEEK 7	WEEK 7
WEEK 8	WEEK 8

COMMENTS:

SURGICAL PROCEDURES

Date
Date
Date
Date
Date

DENIED MEDICATIONS

PREAUTHORIZATIONS

DATE	YES/NO	PROCEDURE

BODY PART DENIED
DATE PLN 1 FILED Y/N
BODY PART DENIED
DATE PLN 1 FILED Y/N
BODY PART DENIED
DATE PLN 1 FILED Y/N
NOTES:

Date: 8/10/10

From: The Texas A&M University System
200 Technology Way. Suite 1120
College Station. Texas 77845

To: Bill Review Department
Starr Comprehensive Solutions. Inc.
P.O. Box 801464
Houston. Texas 77280-1464

RE: REQUEST TO PROCESS BILL AS INSTRUCTED

Claimant: -

Claim # 210-05536-02

Provider: Scott & White

Service Dates:

Please audit the bill as follows:

( ) Fee Schedule Reimbursement.

(X) Claim Denied for Compensability/Liability

( ) Other

Notes: Claim is denied for potential exposure to brucella, but we will cover testing and meds (antibiotics) for preventative care.

Requestor Initials KB

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3977
RECIPIENT ADDRESS	917134624143
DESTINATION ID	
ST. TIME	08/10 14:59
TIME USE	00'18
PAGES SENT	1
RESULT	OK

Date: 8/10/10

From: The Texas A&M University System
200 Technology Way; Suite 1120
College Station, Texas 77845

To: Bill Review Department
Starr Comprehensive Solutions, Inc.
P.O. Box 801464
Houston, Texas 77280-1464

RE: REQUEST TO PROCESS BILL AS INSTRUCTED

Claimant:
Claim # 210-05316-02
Provider: Scott & White
Service Dates:

Please audit the bill as follows:

( ) Fee Schedule Reimbursement.

(X) Claim Denied for Compensability/Liability.

( ) Other:

The Texas A&M University System

Office of the Treasurer
Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Fax: 979-458-6247 Toll Free: 866-249-8574

August 10, 2010

TAMUS # 210-0536-02
DOI: 08/03/2010

Dear Ms.

We are in receipt of your Employer's First Report of Injury concerning a possible exposure to brucella you are claiming as work related.

Please fill out this questionnaire and return as soon as possible.

As soon as this information is received we will evaluate your claim. If you have any questions regarding this form please contact me.

Sincerely,

Kaye Ball

Kaye Ball
Claim Adjuster
Risk Management

enclosure

SUPPLEMENT FOR OCCUPATIONAL DISEASE

INJURED WORKERS' STATEMENT **CLAIM # 210-0536-020**

Name: _____

Social Security Number: _____

Date of Injury: _____
(date knew or should have known of injury)

Location (area) you were working when injury occurred: _____

_____

Body Part Injured: _____
(please indicate if right or left applies)

Describe symptoms you feel may be related to this injury: _____

_____

List any person you feel may have knowledge to support this claim for compensation: _____

_____

List all doctors, along with addresses, you have seen for this condition:

_____

_____

_____

Hobbies: _____

Other Employment: _____
(if any)

Work Telephone Number: _____

Signature: _____

Date: _____

RETURN AS SOON AS POSSIBLE TO:

THE TEXAS A&M UNIVERSITY SYSTEM
Office of the Treasurer Risk Management
A&M System Building, Suite 1120
200 Technology Way
COLLEGE STATION, TEXAS 77845-3424

WORKERS' COMPENSATION
INITIAL STATUS OF CLAIM REPORT

To:	**Jim Kuhlmann**	Date:	**08/10/2010**
	TAMU	RE:	
		Employed By	**TAMU**
		Supervisor:	**Dr. Thomas Ficht**
		D.O.I.:	**08/03/2010**
		Claim No.:	**210-0536-02**

PLEASE USE THE INFORMATION BELOW AS YOU DEEM NECESSARY

☐ We have received a medical bill/report that indicates an injury may have occurred on . Please verify with your records. If an injury occurred forward a copy of the Employer's First Report of Injury or your incident/accident report so we may timely process the medical bill. If an injury has not been reported, please notify this office, in writing, as soon as possible. ***If a response is not received within 3 days of receipt of this notice the claim for compensability will be accepted.***

☐ The employer's First Report of Injury has been received. Weekly compensation benefits will begin after the seven day waiting period pursuant to the Texas Workers' Compensation Act if disability continues **unless a Supplemental Report of Injury is received indicating the employee has returned to work or unless the Request for Paid Leave is received indicating that the employee will use sick and or annual leave.** A wage statement is required if the employee is disabled for more than eight days, even if the employee is using sick/annual leave of FMLA leave.

☐ This claim has been accepted as a compensable injury.

☐ This is a questionable claim. However, sufficient evidence does not exist at this time to contest compensability. Please provide us with written witness statements, and any other objective information that would assist us in making a determination of compensability.

☒ This claim has been denied because:
- ☒ There was no injury in course and scope of employment
- ☐ The injury was not sustained in the course & scope of employment
- ☐ Untimely notice of injury was given
- ☐ The injury is considered an ordinary disease of life
- ☐ Disability only, medical documentation required to establish physical harm
- ☒ Other: Potential Exposure

☒ Other: We are denying the potential exposure, but we will pay for testing and preventative meds and medical care.
Thanks

Please direct any questions regarding this claim and the above information to:

The Texas A&M University System
Office of Risk Management & Safety
College Station, TX 77845-3424
Phone: 979/458-6330 Fax: 979/458-6247

Adjuster: Kaye Ball
F:wci,procedure;office

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
• PH: 979-458-6330 • 866-249-8574 * Fax 979-458-6247 •
http://tamusystem.tamu.edu

August 10, 2010

MEMORANDUM

TO: Dr. Thomas Ficht

SUBJECT:
TAMUS # 210-0536-02
Date of Injury: 08/03/2010

Before I can fully evaluate Ms. alleged work related injury, I will need the following information:

1. Attached statement completed by his/her immediate supervisor.
2. Job Description

If you have any questions please do not hesitate to contact me.

Sincerely,

Kaye Ball

Kaye Ball
Claim Adjuster
Office of Risk Management

enclosure

SUPPLEMENT FOR OCCUPATIONAL DISEASE

SUPERVISOR'S STATEMENT **CLAIM # 210-0536-02**

Injured Employee:

Social Security Number:

Date of Injury: _____

(date knew or should have known of injury)

Location (area) employee was working when injury occurred: _____

_____

Body Part Injured: _____

(please indicate if right or left applies)

Describe symptoms and dates reported by employee for this injury: _____

_____

_____

List any person you feel may have knowledge to support this claim for compensation: _____

_____

Please indicate number of job tasks routinely required which may be related to an occupational exposure injury: _____

_____

_____

_____

Signature: _____

Date: _____

RETURN AS SOON AS POSSIBLE TO:

THE TEXAS A&M UNIVERSITY SYSTEM
OFFICE OF THE TREASURER
200 TECHNOLOGY WAY, SUITE 1120
COLLEGE STATION, TEXAS 77845-3424

CHECK LIST FOR NEW FOLDERS

- ☐ Prepare lost time chart
- ☑ Acceptance Letter
- ☑ Contact injured employee for statement by telephone (date 11/23/10)
- ☑ Employer initial status of claim (date 11/23/10)
  - ☐ Wage statement
  - ☐ Request for Paid Leave
  - ☐ Supplemental
  - ☑ Request emailed on _____
- ☑ Initial questionnaire to Claimant
- ☐ Work status tracking log
- ☐ Copy of work status to employer
- ☐ Update work status in Allegro
- ☑ Update claim notes for extent of injury & controverted
- ☐ PLN ☐1 _____ ☐2 _____ ☐6 _____ ☐11 _____
- ☐ EDI 1st report Did Salary Continue? Y or N _____
- ☐ DWC Record Check
- ☐ Request witness statement
- ☐ COMP Divider
- ☑ Diary
  - ☐ PLN 11 (define extent of injury within first 60 days)
  - ☐ 8th day, elimination week, 26 weeks, & FMLA ends

Subrogated claim:

- ☐ Notice to claimant
- ☐ Notice to 3rd party
- ☐ Notice to 3rd party insurance
- ☐ Request accident report

Work status change:

- ☐ Update lost time in Allegro
- ☐ Update work status tracking log
- ☐ Copy of work status to Employer

Impairment benefits:

- ☑ PLN 3
- ☑ Update Allegro MMI/IR
- ☐ Subsequent Status Claim Form to Employer
- ☐ Request Wage Statement

Revised 7 05

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Toll Free: 866-249-8574 • Fax 979-458-6247 • http://tamusystem.tamu.edu

Resent 2/8/11
KB

NOTIFICATION OF MAXIMUM MEDICAL IMPROVEMENT/FIRST IMPAIRMENT INCOME BENEFIT PAYMENT

DATE: **January 13, 2011**

Certified Mail Return Receipt Requested:
7009 1680 0001 0282 2946

TO: **NAME OF INJURED EMPLOYEE:**
ADDRESS:
CITY, STATE, ZIP:

RE: **DATE OF INJURY: 11/15/2010**
NATURE OF INJURY: Laceration/Exposure
PART OF BODY INJURED: Right Index Finger/Brucella
SSN:
DWC #: Unknown
CARRIER/TPA NAME: The Texas A&M University System
CARRIER CLAIM#: 211-0134-23
NAME OF EMPLOYER: Texas A&M Health Science Center
EMPLOYER ADDRESS: 301 Tarrow Street, 6th Floor
EMPLOYER CITY, STATE, ZIP: College Station, TX 77840

You have been certified to have reached Maximum Medical Improvement (MMI) and had an Impairment Rating (IR) assigned. Entitlement to Impairment Income Benefits (IIBs) begins the day after the date you were certified as having reached MMI. For each percentage point of impairment rating, you will receive 3 weeks of benefits. The amount of your IIBs benefit is based on 70% of the reported Average Weekly Wage of $479.12.

We have received a report from Dr. Eric Wilke, M.D. (copy attached) certifying that you have reached MMI and you do not have any permanent impairment as a result of this compensable injury. Based on this report you are not eligible for any income benefits of any type. You remain entitled to necessary medical benefits related to this injury.

If you are expected to be paid benefits for a period of eight weeks or more, you may request that we make benefit payments by electronic funds transfer directly to your bank account. Also, you may request that we change your IIBs to a monthly payment.

Explanatory Comments:

If you do not agree with this certification of MMI and/or IR you have 90 days from the date you receive this notication of MMI and/or IR to file a dispute with the Texas Department of Insurance, Division of Workers' Compensation by contacting the Division office handling your claim at 1-800-252-7031.

If you are interested in having your payments made directly to your bank account or do not agree with the finding of MMI, IR certified by the doctor, or the amount being paid please contact me:

Adjuster's Name:	**Kaye Ball**
Toll Free Telephone #:	**1-866-249-8574**
Fax #/E-mail Address:	**1-979-458-6247/KBall@tamu.edu**

If we are unable to resolve the issue to your satisfaction, you have the right to file a dispute with the Texas Department of Insurance, Division of Workers' Compensation. For assistance contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

Cc:

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(800)-252-7031.

Empleado - Es necesario que reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que se lesionó si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte de la División de Compensación para Trabajadores, y también puede tener derecho a ciertos beneficios médicos y monetarios. Para mayor información comuníquese con la oficina local de la División al teléfono 1-800-252-7031.

REPORT OF MEDICAL EVALUATION

CLAIM #: 211-01324-230[illegible]

PART I: GENERAL INFORMATION

1 Workers' Compensation Insurance Carrier:

2 Employer's Name: Texas A&M University Systems

3 Employer's Address: 200 Technology Way, Suite 1120

City: College Station, State: TX, Zip: 77845

4 Injured Employee's Name (Last, First, MI):

5 Date of Injury: 11/15/2010

6 Social Security Number: X

7 Employee's Phone #:

8 Employee's Address:

City: College Station, State: TX, Zip: 77845

9 Certifying Doctor's Name and Licenses: Dr. Eric Wilke M.D. L0697

10 Certifying Doctor's License Number and Jurisdiction: L0697 TX

11 Certifying Doctor's Phone & Fax #: PH (979) 680-9675 (FAX) (979) 845-8650

12 Certifying Doctor's Address: 1605 Rock Prairie Road, Suite 100

City: College Station, State: TX, Zip: 77845

PART II: DOCTOR'S ROLE AND CERTIFICATION

13. Indicate which role you are serving in the claim in performing this evaluation. Only a doctor serving in one of the following roles is authorized to evaluate MMI/impairment and file this report (Workers' Compensation Rule 130.1 governs such authorization):

☑ Treating Doctor ☐ Doctor Selected by Treating Doctor acting in place of the Treating Doctor ☐ Designated Doctor Selected by the Division

☐ Carrier-Selected RME Doctor approved by the Division to evaluate MMI and/or permanent impairment after a Designated Doctor examination.

NOTE –If you are not authorized by Rule 130.1 to file this report, you will not be paid for this report or the MMI/impairment examination.

14. I HEREBY CERTIFY THAT THIS REPORT OF MEDICAL EVALUATION is complete and accurate and complies with the Texas Workers' Compensation Act and applicable rules, and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature of Certifying Doctor: [signature] MD Date of Certification: 12/23/2010

PART III: MEDICAL STATUS INFORMATION

15 Date of Exam: 12/23/2010

16 Diagnosis (ICD-9 Codes): 1) 915.8 2) V01.9 3) 4)

17. Indicate whether the employee has reached Clinical or Statutory MMI based upon the following definitions:

Clinical Maximum Medical Improvement (Clinical MMI) is the earliest date after which, based upon reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated.

Statutory MMI is the later of: (1) the end of the 104th week after the date that temporary income benefits (TIBs) began to accrue; or (2) the date to which MMI was extended by the Division through operation of Texas Labor Code §408.104.

a) ☑ Yes, I certify that the employee reached ☐ STATUTORY / ☑ CLINICAL (mark one) MMI on 12/23/2010 (may not be a prospective date) and have included documentation relating to this certification in the attached narrative. OR

b) ☐ No, I certify that the employee has NOT reached MMI but is expected to reach MMI on or about _____. The reason the employee has not reached MMI is documented in the attached narrative.

NOTE – The fact that an employee reaches either Clinical MMI or Statutory MMI does not signify that the employee is no longer entitled to medical benefits.

PART IV: PERMANENT IMPAIRMENT

18. If the employee has reached MMI, indicate whether the employee has permanent impairment as a result of the compensable injury.

"Impairment" means any anatomic or functional abnormality or loss existing after MMI that results from a compensable injury and is reasonably presumed to be permanent. The finding that impairment exists must be made based upon objective clinical or laboratory findings meaning a medical finding of impairment resulting from a compensable injury based upon competent objective medical evidence that is independently confirmable by a doctor, including a designated doctor, without reliance on the subjective symptoms perceived by the employee.

a) ☑ I certify that the employee does not have any permanent impairment as a result of the compensable injury. OR

b) ☐ I certify that the employee has permanent impairment as a result of the compensable injury. The amount of permanent impairment is _____%, which was determined in accordance with the requirements of the Texas Workers' Compensation Act and Workers' Compensation Rules. The attached narrative provides documentation involved in the calculation of the impairment rating assigned using the following edition of the Guides to the Evaluation of Permanent Impairment published by the American Medical Association (AMA): ☐ third edition, second printing, February 1989. OR ☐ fourth edition, 1st, 2nd, 3rd, or 4th printing, including corrections and changes issued by the AMA prior to May 18, 2000.

PART V: TREATING DOCTOR'S AGREEMENT OR DISAGREEMENT WITH ANOTHER DOCTOR'S CERTIFICATION

19 Treating Doctor's Name and Degree: Dr. Eric Wilke M.D. L0697

20 Treating Doctor's License Number and Jurisdiction: L0697 TX

21 Treating Doctor's Phone & Fax #: PH (979) 680-9675 (FAX) (979) 845-8650

22 ☐ I AGREE / ☐ I DISAGREE with the certifying doctor's certification of MMI.

23 ☐ I AGREE / ☐ I DISAGREE with the certifying doctor's finding of no impairment. OR

☐ I AGREE / ☐ I DISAGREE with the impairment rating assigned by the certifying doctor.

24. I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature of Treating Doctor: [signature] MD Date: 12/23/2010

NOTE: With few exceptions, you are entitled by law to know, review, and correct information that DWC collects on its forms about you. For more information, call our Open Records section at 512-804-4437.

NOTA: Usted tiene derecho por ley de saber, revisar y corregir información que la División ha recogido en sus formularios con algunas excepciones. Para mayor información llame a la sección de archivo abierto "Open Records" al teléfono 512-804-4437.

TAMUS RISK MANAGEMENT OFFICE
2011 JAN 11 AM 9:56
DIVISION OF WORKERS' COMPENSATION
RECEIVED

DWC FORM-69 (Rev 10/05) Page 1

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	4739
RECIPIENT ADDRESS	917134624143
DESTINATION ID	
ST. TIME	01/14 11:20
TIME USE	00'23
PAGES SENT	1
RESULT	OK

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Toll Free: 866-249-8574 • Fax 979-458-6247 • http://tamusystem.tamu.edu

NOTICE OF DISPUTED ISSUE(s) AND REFUSAL TO PAY BENEFITS

DATE: January 13, 2011

TO: NAME OF INJURED EMPLOYEE:
ADDRESS:
CITY, STATE, ZIP:

FAXED TO STARR
DATE: 1/14/11 pe

RE: DATE OF INJURY: 11/15/2010
NATURE OF INJURY: Laceration/Exposure to Brucella
PART OF BODY INJURED: Right Index Finger
EMPLOYEE SSN:
DWC #: Unknown
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 211-0134-23
EMPLOYER NAME: Texas A&M Health Science Center
EMPLOYER ADDRESS: 301 Tarrow Street, 6th Floor
EMPLOYER CITY, STATE, ZIP: College Station, TX 77840

We are disputing entitlement of medical treatment for any body part, medical condition, or diagnosis other than a laceration and exposure to brucella, only because:

The Texas A&M University System as the workers' compensation insurance carrier for Texas A&M Health Science Center disputes entitlement of medical treatment for any body part, medical condition, or diagnosis other than a laceration and exposure to brucella, only, that occurred on or about 11/15/2010. Carrier disputes that the compensable injury extends to and includes any and all other body parts and/or medical conditions.

If you do not agree with the dispute and refusal to pay benefits, please contact me:

Adjuster's Name: **Kaye Ball**
Toll Free Telephone #: **1-866-249-8574**
Fax #/E-mail Address: **1-979-458-6247/KBall@tamu.edu**

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. Contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines

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NOTICE OF DISPUTED ISSUE(s) AND REFUSAL TO PAY BENEFITS

DATE: January 13, 2011

TO: NAME OF INJURED EMPLOYEE:
ADDRESS:
CITY, STATE, ZIP:

FAXED TO STARR
DATE: 1/14/11 pe

RE: DATE OF INJURY: 11/15/2010
NATURE OF INJURY: Laceration/Exposure to Brucella
PART OF BODY INJURED: Right Index Finger
EMPLOYEE SSN:
DWC #: Unknown
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 211-0134-23
EMPLOYER NAME: Texas A&M Health Science Center
EMPLOYER ADDRESS: 301 Tarrow Street, 6th Floor
EMPLOYER CITY, STATE, ZIP: College Station, TX 77840

We are disputing entitlement of medical treatment for any body part, medical condition, or diagnosis other than a laceration and exposure to brucella, only because:

The Texas A&M University System as the workers' compensation insurance carrier for Texas A&M Health Science Center disputes entitlement of medical treatment for any body part, medical condition, or diagnosis other than a laceration and exposure to brucella, only, that occurred on or about 11/15/2010. Carrier disputes that the compensable injury extends to and includes any and all other body parts and/or medical conditions.

If you do not agree with the dispute and refusal to pay benefits, please contact me:

Adjuster's Name: Kaye Ball
Toll Free Telephone #: 1-866-249-8574
Fax #/E-mail Address: 1-979-458-6247/KBall@tamu.edu

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. Contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

Cc: DWC, 7551 Metro Center Drive, Ste. 100, Austin, Texas 78744-1645

The Texas A&M University System

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Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
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NOTIFICATION OF MAXIMUM MEDICAL IMPROVEMENT/FIRST IMPAIRMENT INCOME BENEFIT PAYMENT

DATE: **January 13, 2011**

Certified Mail Return Receipt Requested:
7009 1680 0001 0282 2946

TO: **NAME OF INJURED EMPLOYEE:**
ADDRESS:
CITY, STATE, ZIP:

RE: **DATE OF INJURY: 11/15/2010**
NATURE OF INJURY: Laceration/Exposure
PART OF BODY INJURED: Right Index Finger/Brucella
SSN:
DWC #: Unknown
CARRIER/TPA NAME: The Texas A&M University System
CARRIER CLAIM#: 211-0134-23
NAME OF EMPLOYER: Texas A&M Health Science Center
EMPLOYER ADDRESS: 301 Tarrow Street, 6th Floor
EMPLOYER CITY, STATE, ZIP: College Station, TX 77840

You have been certified to have reached Maximum Medical Improvement (MMI) and had an Impairment Rating (IR) assigned. Entitlement to Impairment Income Benefits (IIBs) begins the day after the date you were certified as having reached MMI. For each percentage point of impairment rating, you will receive 3 weeks of benefits. The amount of your IIBs benefit is based on 70% of the reported Average Weekly Wage of $479.12.

We have received a report from Dr. Eric Wilke, M.D. (copy attached) certifying that you have reached MMI and you do not have any permanent impairment as a result of this compensable injury. Based on this report you are not eligible for any income benefits of any type. You remain entitled to necessary medical benefits related to this injury.

If you are expected to be paid benefits for a period of eight weeks or more, you may request that we make benefit payments by electronic funds transfer directly to your bank account. Also, you may request that we change your IIBs to a monthly payment.

Explanatory Comments:

If you do not agree with this certification of MMI and/or IR you have 90 days from the date you receive this notication of MMI and/or IR to file a dispute with the Texas Department of Insurance, Division of Workers' Compensation by contacting the Division office handling your claim at 1-800-252-7031.

If you are interested in having your payments made directly to your bank account or do not agree with the finding of MMI, IR certified by the doctor, or the amount being paid please contact me:

Adjuster's Name:	**Kaye Ball**
Toll Free Telephone #:	**1-866-249-8574**
Fax #/E-mail Address:	**1-979-458-6247/KBall@tamu.edu**

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For delivery information visit our website at www.usps.com
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Return Receipt Fee (Endorsement Required)
TAMUS RISK MANAGEMENT
Postmark Here
Restricted Delivery Fee (Endorsement Required)
Total Postage & Fees $
211-0134-23
Sent To
Street, Apt. No., or PO Box
City, State, ZIP+4
See Reverse for Instructions
7009 1680 0001 0282 2946

e the right to file a dispute with the Texas Department of Insurance, Division of lice handling your claim at 1-800-252-7031.

ail, please contact me and provide your facsimile number or e-mail address.

ation claim is a crime that may result in fines and/or imprisonment.

Universities
l University • Texas A&M University • Texas A&M University at Galveston • Texas A&M University-Commerce
versity-Kingsville • Texas A&M University-Texarkana • West Texas A&M University

Agencies
exas Engineering Experiment Station • Texas Engineering Extension Service • Texas Forest Service
ical Diagnostic Laboratory • Texas A&M University System Health Science Center

Employee - You are required to report your injury to your employer within 30 days or your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(800)-252-7031.

Empleado - Es necesario que reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que se lesionó si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte de la División de Compensación para Trabajadores, y también puede tener derecho a ciertos beneficios médicos y monetarios. Para mayor información comuníquese con la oficina local de la División al teléfono 1-800 252 7031.

REPORT OF MEDICAL EVALUATION

CLAIM #: 11-0134-23[illegible]B

PART I: GENERAL INFORMATION

1. Workers' Compensation Insurance Carrier:
2. Employer's Name: Texas A&M University Systems
3. Employer's Address: 200 Technology Way, Suite 1120
   City: College Station, State: TX, Zip: 77845
4. Injured Employee's Name (Last, First, MI):
5. Date of Injury: 11/15/2010
6. Social Security Number:
7. Employee's Phone: (979) 764-6656
8. Employee's Address:
   City: State: Zip:
9. Certifying Doctor's Name and Licensure: Dr. Eric Wilke M.D. L0697
10. Certifying Doctor's License Number and Jurisdiction: L0697 TX
11. Certifying Doctor's Phone & Fax #: (Ph) (979) 680-9675 (Fax) (979) 845-8650
12. Certifying Doctor's Address: 1605 Rock Prairie Road, Suite 100
    City: College Station, State: TX, Zip: 77845

PART II: DOCTOR'S ROLE AND CERTIFICATION

13. Indicate which role you are serving in the claim in performing this evaluation. Only a doctor serving in one of the following roles is authorized to evaluate MMI/impairment and file this report (Workers' Compensation Rule 130.1 governs such authorization):

☑ Treating Doctor ☐ Doctor Selected by Treating Doctor acting in place of the Treating Doctor ☐ Designated Doctor Selected by the Division
☐ Carrier-Selected RME Doctor approved by the Division to evaluate MMI and/or permanent impairment after a Designated Doctor examination.

NOTE – If you are not authorized by Rule 130.1 to file this report, you will not be paid for this report or the MMI/impairment examination.

14. I HEREBY CERTIFY THAT THIS REPORT OF MEDICAL EVALUATION is complete and accurate and complies with the Texas Workers' Compensation Act and applicable rules, and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature of Certifying Doctor: [signature] MD Date of Certification: 12/23/2010

PART III: MEDICAL STATUS INFORMATION

15. Date of Exam: 12/23/2010
16. Diagnosis (ICD-9 Codes): 1) 915.8 2) V01.9 3) 4)
17. Indicate whether the employee has reached Clinical or Statutory MMI based upon the following definitions:

Clinical Maximum Medical Improvement (Clinical MMI) is the earliest date after which, based upon reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated.

Statutory MMI is the later of: (1) the end of the 104th week after the date that temporary income benefits (TIBs) began to accrue; or (2) the date to which MMI was extended by the Division through operation of Texas Labor Code §408.104.

a) ☑ Yes, I certify that the employee reached ☐ STATUTORY / ☑ CLINICAL (mark one) MMI on 12/23/2010 (may not be a prospective date) and have included documentation relating to this certification in the attached narrative. OR

b) ☐ No, I certify that the employee has NOT reached MMI but is expected to reach MMI on or about _____. The reason the employee has not reached MMI is documented in the attached narrative.

NOTE – The fact that an employee reaches either Clinical MMI or Statutory MMI does not signify that the employee is no longer entitled to medical benefits.

PART IV: PERMANENT IMPAIRMENT

18. If the employee has reached MMI, indicate whether the employee has permanent impairment as a result of the compensable injury.

"Impairment" means any anatomic or functional abnormality or loss existing after MMI that results from a compensable injury and is reasonably presumed to be permanent. The finding that impairment exists must be made based upon objective clinical or laboratory findings meaning a medical finding of impairment resulting from a compensable injury, based upon competent objective medical evidence that is independently confirmable by a doctor, including a designated doctor, without reliance on the subjective symptoms perceived by the employee.

a) ☑ I certify that the employee does not have any permanent impairment as a result of the compensable injury. OR

b) ☐ I certify that the employee has permanent impairment as a result of the compensable injury. The amount of permanent impairment is _____%, which was determined in accordance with the requirements of the Texas Workers' Compensation Act and Workers' Compensation Rules. The attached narrative provides documentation involved in the calculation of the impairment rating assigned using the following edition of the Guides to the Evaluation of Permanent Impairment published by the American Medical Association (AMA): ☐ third edition, second printing, February 1989. OR ☐ fourth edition, 1st, 2nd 3rd, or 4th printing, including corrections and changes issued by the AMA prior to May 16, 2000.

PART V: TREATING DOCTOR'S AGREEMENT OR DISAGREEMENT WITH ANOTHER DOCTOR'S CERTIFICATION

19. Treating Doctor's Name and Degree: Dr. Eric Wilke M.D. L0697
20. Treating Doctor's License Number and Jurisdiction: L0697 TX
21. Treating Doctor's Phone & Fax #: (Ph) (979) 680-9675 (Fax) (979) 845-8650
22. ☐ I AGREE / ☐ I DISAGREE with the certifying doctor's certification of MMI.
23. ☐ I AGREE / ☐ I DISAGREE with the certifying doctor's finding of no impairment. OR
    ☐ I AGREE / ☐ I DISAGREE with the impairment rating assigned by the certifying doctor.
24. I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature of Treating Doctor: [signature] MD Date: 12/23/2010

NOTE: With few exceptions, you are entitled by law to know, review, and correct information that DWC collects on its forms about you. For more information, call our Open Records section at 512-804-4437.
NOTA: Usted tiene derecho por ley de saber, revisar y corregir información que la División ha recogido en sus formularios con algunas excepciones. Para mayor información llame a la sección de archivo abierto "Open Records" al teléfono 512-804-4437.

DWC FORM-69 (Rev. 10/06) Page 1

RECEIVED
TAMUS
Date Stamp
2011 JAN 11 AM 9:56
OFFICE OF RISK MANAGEMENT
DIVISION OF WORKERS' COMPENSATION

INITIAL RESERVES
MEDICAL _____
INDEMNITY _____
LAE _____

LOST TIME Y/N ADJUSTER KB Compensation, g.

CLAIM # _____

CARRIER'S CLAIM # 211-0134-23

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)	2. Sex F ☒ M ☐
[redacted]	3
4. Does the employee Speak English? If No, Specify Language: YES ☒ NO ☐	
5. Race White ☒ Black ☐ Asian ☐	6. Ethnicity Hispanic ☐ Native American ☐ Other ☐
8. Mailing Address Street or P.O. Box [redacted]	
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☒ Divorced ☐	
11. [redacted]	
City College Station, TX 77845 State Zip Code	

15. Date of Injury (m-d-y) 11-15-10	16. Time of Injury 3:00 am ☐ pm ☒	17. Date Lost Time Began (m-d-y) NA.
18. Nature of Injury* laceration	19. Part of Body Injured or Exposed* rt. index finger .5cm	
20. How and Why Injury/Illness Occurred* scalpel injury - blade loaded incorrectly		
21. Was employee doing his regular job? YES ☒ NO ☐	22. Worksite Location of Injury (state, dock, etc.)* large animal laboratory 1220 Vet. Med. Park, TAMU	
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site: Vet. Med Park Bldg. 1220 Street or P.O. Box; County TAMU		
City College Station State TX Zip Code 77845-		
24. Cause of Injury(fall, tool, machine, etc.)* scalpel blade loaded wroxy way		
25. List Witnesses Annie To,		

26. Return to work date/or expected (m-d-y) 11-15-10	27. Did employee die? YES ☐ NO ☒	28. Supervisor's Name Allison Fiala	29. Date Reported (m-d-y) 11.15.10

30. Date of Hire (m-d-y) 9-1-2010	31. Was employee hired or recruited in Texas? YES ☒ NO ☐	32. Length of Service in Current Position Months 2½ Years _____	33. Length of Service in Occupation Months 2½ Years _____
34. Employee Payroll Classification Code 8832	35. Occupation of Injured Worker Research Assistant		
36. Rate of Pay at this Job $2083.33 Monthly $_____ Hourly $_____ Weekly	37. Full Work Week is: 40 Hours 5 Days	38. Last Paycheck was: 11/1/10 $_____ for _____ Hours or 21 Days	39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☒

40. Name and Title of Person Completing Form Allison R. Fiala, Professor	41. Name of Business
42. Business Mailing Address and Telephone Number Street or P.O. Box Molecular & Cellular Med. Telephone (979) 845-2726	43. Business Location (if different from mailing address) Number and Street
City College Station State TX Zip Code 77843-1114	City State Zip Code

44. Federal Tax Identification Number	45. Primary North American Industry Classification System Code: (6 digit)	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.
48. Workers' Compensation Insurance Company	49. Policy Number		

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X Allison R. Fiala Date 11/18/10

RECEIVED
2010 NOV 19 AM 9:34
OFFICE OF TAMUS RISK MANAGEMENT

DWC FORM-1 (Rev. 10/05) Page 3

Entered 11/22 QA
DIVISION OF WORKERS' COMPENSATION

Coffer, Lisa

21ϕ-0134-23

From: Coffer, Lisa
Sent: Wednesday, November 17, 2010 8:41 AM
To: Walton, Matt
Subject: RE:

Matt,

We have received a work status indicating a date of injury of 11/15/2010 for the above named employee. Would you check with the department involved and if a DWC 1 is found to be on file for this injury, please forward a copy to our office within two business days? If you do not find an injury report on file, simply let us know within the same two business days. Thank you for your assistance and reply.

Lisa Coffer
Texas A&M University System
Risk Management and Safety
979-458-6330
lcoffer@tamu.edu
wci@tamu.edu

214-0134-23

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(800)-252-7031.

Empleado - Es necesario que reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que se lesionó si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte de la División de Compensación para Trabajadores, y también puede tener derecho a ciertos beneficios médicos y monetarios. Para mayor información comuníquese con la oficina local de la División al teléfono 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

(for transmission purposes only) Date Being Sent: 11/16/2010

PART I: GENERAL INFORMATION

1. Injured Employee's Name:
2. Date of Injury: 11/15/2010
3. Social Security Number:
4. Employee's Description of Injury/Accident: Pt states she cut her finger with a scalpel while cleaning up after a goat necropsy. Goat was positive for Brucella encapsulated delta VJBR 10 to the sixth.
5. Doctor's Name and Degree: Nicole L. Kroll, RN ANP-C
6. Clinic/Facility Name: CS Medical Center Occupational Medicine
7. Clinic/Facility/Doctor Phone & Fax: (979) 680-9675 (979) 485-8650
8. Clinic/Facility/Doctor Address (street address): 1605 Rock Prairie Road
City: College Station, State: TX, Zip: 77845
9. Employer's Name: Texas A&M University Systems
10. Employer's Fax # or Email Address (if known): (979) 458-6247 d-hollsday01@tamu.edu
11. Insurance Carrier:
12. Carrier's Fax # or Email Address (if known):

PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE)

13. The injured employee's medical condition resulting from the workers' compensation injury:
(a) ☑ will allow the employee to return to work as of 11/15/2010 (date) without restrictions.
(b) ☐ will allow the employee to return to work as of _____ (date) with the restrictions identified in PART III, which are expected to last through _____ (date).
(c) ☐ has prevented and still prevents the employee from returning to work as of _____ (date) and is expected to continue through _____ (date). The following describes how this injury prevents the employee from returning to work:

PART III: ACTIVITY RESTRICTIONS (ONLY COMPLETE IF BOX 13(b) IS CHECKED)

14. POSTURE RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Standing	☐	☐	☐	☐	☐	
Sitting	☐	☐	☐	☐	☐	
Kneeling/Squatting	☐	☐	☐	☐	☐	
Bending/Stooping	☐	☐	☐	☐	☐	
Pushing/Pulling	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	

15. RESTRICTIONS SPECIFIC TO (if applicable):

☐ L Hand/Wrist ☐ R Hand/Wrist
☐ L Arm ☐ R Arm ☐ Neck
☐ L Leg ☐ R Leg ☐ Back
☐ L Foot/Ankle ☐ R Foot/Ankle
☐ Other:

17. MOTION RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Walking	☐	☐	☐	☐	☐	
Climbing stairs/ladder	☐	☐	☐	☐	☐	
Grasping/Squeezing	☐	☐	☐	☐	☐	
Wrist flexion/extension	☐	☐	☐	☐	☐	
Reaching	☐	☐	☐	☐	☐	
Overhead Reaching	☐	☐	☐	☐	☐	
Keyboarding	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	

18. LIFT/CARRY RESTRICTIONS (if any):

☐ May not lift/carry objects more than ____ lbs. for more than ____ hours per day
☐ May not perform any lifting/carrying
☐ Other:

19. MISC. RESTRICTIONS (if any):

☐ Max hours per day of work: _____
☐ Sit/Stretch breaks of _____ per _____
☐ Must wear splint/cast at work
☐ Must use crutches at all times
☐ No Driving/operating heavy equipment
☐ Can only drive automatic transmission
☐ No work / ☐ _____ hours/day work:
☐ In extreme hot/cold environments
☐ at heights or on scaffolding
☐ Must keep: _____
☐ Elevated ☐ Clean & Dry
☐ No skin contact with _____
☐ Dressing changes necessary at work
☐ No Running

16. OTHER RESTRICTIONS (if any):

None.

* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work.

20. MEDICATION RESTRICTIONS (if any):

☑ Must take prescription medication(s)
☐ Advised to take over-the-counter meds
☐ Medication may make drowsy (possible Safety/driving issues)

RECEIVED 2010 NOV 19 AM 9:34 OFFICE OF RISK MANAGEMENT

PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

21. Work Injury Diagnosis Information:

1. Other & unspecified superficial injury of finger with out infections (915.8). 2. Infectious Disease, Exposure (V01.9).

22 Expected Follow-up Services Include:

☑ Evaluation by the treating doctor on 11/22/2010 (date) at 4:00 pm
☐ Referral to/Consult with _____ on _____ (date) at _____
☐ Physical medicine ___ X per week for ___ weeks starting on _____ (date) at _____
☐ Special studies (list): _____ on _____ (date) at _____
☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date / Time of Visit	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type:	Role of Doctor:
11/15/2010 4:00 pm		Nicole Kroll, RN, ANP-C	☑ Initial ☐ Follow-up	☐ Designated doctor ☐ Carrier-selected RME ☐ DWC-selected RME ☑ Treating doctor ☐ Referral doctor ☐ Consulting doctor ☐ Other doctor
Discharge Time: 4:45 pm				

DIVISION OF WORKERS' COMPENSATION

20-0134-23 CB

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(800)-252-7031.

Empleado - Es necesario que reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que se lesionó si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte de la División de Compensación para Trabajadores, y también puede tener derecho a ciertos beneficios médicos y monetarios. Para mayor información comuníquese con la oficina local de la División al teléfono 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

PART I: GENERAL INFORMATION

1. Injured Employee's Name

2. Date of Injury: 11/15/2010

3. Social Security Number

4. Employee's Description of Injury/Accident: Pt states she cut her finger with a scalpel while cleaning up after a goat necropsy. Goat was positive for Brucella encapsulated delta VJBR 10 to the sixth.

5. Doctor's Name and Degree: Nicole L. Kroll, RN ANP-C

6. Clinic/Facility Name: CS Medical Center Occupational Medicine

7. Clinic/Facility/Doctor Phone & Fax: (979) 680-9675 (979) 485-8650

8. Clinic/Facility/Doctor Address (street address): 1605 Rock Prairie Road

City: College Station State: TX Zip: 77845

(for transmission purposes only)

Date Being Sent: 11/16/2010

9. Employer's Name: Texas A&M University System

10. Employer's Fax # or Email Address (if known): (979) 458-6247 d-holladay@tamu.edu

11. Insurance Carrier

12. Carrier's Fax # or Email Address (if known)

RECEIVED NOV 22 2010 FIC FLAMUS RISK MANAGEMENT

PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE)

13. The injured employee's medical condition resulting from the workers' compensation injury:

(a) ☑ will allow the employee to return to work as of 11/15/2010 (date) without restrictions.

(b) ☐ will allow the employee to return to work as of _____ (date) with the restrictions identified in PART III, which are expected to last through _____ (date).

(c) ☐ has prevented and still prevents the employee from returning to work as of _____(date) and is expected to continue through _____(date). The following describes how this injury prevents the employee from returning to work:

PART III: ACTIVITY RESTRICTIONS* (ONLY COMPLETE IF BOX 13(b) IS CHECKED)

14. POSTURE RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Standing	☐	☐	☐	☐	☐	
Sitting	☐	☐	☐	☐	☐	
Kneeling/Squatting	☐	☐	☐	☐	☐	
Bending/Stooping	☐	☐	☐	☐	☐	
Pushing/Pulling	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	

15. RESTRICTIONS SPECIFIC TO (if applicable):

☐ L Hand/Wrist ☐ R Hand/Wrist
☐ L Arm ☐ R Arm ☐ Neck
☐ L Leg ☐ R Leg ☐ Back
☐ L Foot/Ankle ☐ R Foot/Ankle
☐ Other:

17. MOTION RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Walking	☐	☐	☐	☐	☐	
Climbing stairs/ladder	☐	☐	☐	☐	☐	
Grasping/Squeezing	☐	☐	☐	☐	☐	
Wrist flexion/extension	☐	☐	☐	☐	☐	
Reaching	☐	☐	☐	☐	☐	
Overhead Reaching	☐	☐	☐	☐	☐	
Keyboarding	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	

18. LIFT/CARRY RESTRICTIONS (if any):

☐ May not lift/carry objects more than ____ lbs. for more than ____ hours per day
☐ May not perform any lifting/carrying
☐ Other:

19. MISC. RESTRICTIONS (if any):

☐ Max hours per day of work: _____
☐ Sit/Stretch breaks of _____ per _____
☐ Must wear splint/cast at work
☐ Must use crutches at all times
☐ No Driving/operating heavy equipment
☐ Can only drive automatic transmission
☐ No work / ☐ _____ hours/day work:
☐ In extreme hot/cold environments
☐ at heights or on scaffolding
☐ Must keep: _____
☐ Elevated ☐ Clean & Dry
☐ No skin contact with: _____
☐ Dressing changes necessary at work
☐ No Running

16. OTHER RESTRICTIONS (if any):

None.

20. MEDICATION RESTRICTIONS (if any):

☑ Must take prescription medication(s)
☐ Advised to take over-the-counter meds
☐ Medication may make drowsy (possible Safety/driving issues)

* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work.

PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

21. Work Injury Diagnosis Information:

1. Other & unspecified superficial injury of finger with out infections (915.8). 2. Infectious Disease, Exposure (V01.9).

22 Expected Follow-up Services Include:

☑ Evaluation by the treating doctor on 11/22/2010 (date) at 4:00 pm
☐ Referral to/Consult with _____ on _____ (date) at _____
☐ Physical medicine ___ X per week for ___ weeks starting on _____ (date) at _____
☐ Special studies (list): _____ on _____ (date) at _____
☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date / Time of Visit	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type:	Role of Doctor:	
11/15/2010 4:00 pm		Nicole Kroll, RN, ANP-C	☑ Initial ☐ Follow-up	☐ Designated doctor ☐ Carrier-selected RME ☐ DWC-selected RME	☑ Treating doctor ☐ Referral doctor ☐ Consulting doctor ☐ Other doctor
Discharge Time 4:45 pm					

DIVISION OF WORKERS' COMPENSATION

211-0134-23

College Station
Medical Center
Occupational Medicine

1605 Rock Prairie Rd, Suite 100
College Station, TX, 77845
(979) 680-WORK (9675)
Fax (979) 485-8650

FAX

To: Deana Hollada	From: [redacted]
Fax: 979-458-6249	Pages: 2
Phone: 979-458-6330	Date: 11/16/10
Re: [redacted]	cc:

Comm

I will follow up on 11/22 & we will get her to sign then. Sorry for any inconvenience.

[redacted]

RECEIVED
2010 NOV 19 AM 9:34
TAMUS
OFFICE OF RISK MANAGEMENT

INITIAL CLAIM QUESTIONNAIRE

Claimant:
Address:

Claim # 211-0134-23
Date of Injury: 11/15/2010
Date mailed: 11/22/2010

Please complete, sign, and date this claims questionnaire and return in the enclosed postage paid envelope as soon as possible.

1. Did your injury occur while performing your normal job duties?

2. Please state in your own words where and how your injury occurred.

3. Please state in your own words any physical harm or damage to your body that resulted from the work related incident.

4. Have you sought medical attention for this injury? If so please indicate your choice of primary care physician. Have you seen this physician in the past three years for other conditions whether work related or not.

5. If you have multiple employers please list the name and address of each employer

Injured employee signature

Date

c inques

The Texas A&M University System

Office of the Treasurer
Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Fax 979-458-6247 • http://tamusystem.tamu.edu

November 22, 2010

Dear ,

This office is in receipt of a First Report of Injury indicating that you sustained a work-related injury on 11/15/2010.

Any medical bills you incur as a direct result of this injury should be immediately forwarded to this office for consideration. Prescription drugs may be filled at any pharmacy. Please do not use your health care insurance to have these prescriptions filled.

If you miss more than a day of work as result of this injury you must contact your department to ensure that you receive all the benefits to which you may be entitled.

If you have any questions regarding your claim, please come by our office or call us at (979) 458-6330.

Sincerely,

Kaye Ball

KAYE BALL
Workers' Compensation Insurance
Risk Management Division

Enclosure

THE TEXAS A&M UNIVERSITY SYSTEM

Kay Ball
WCI Claims Adjuster
Risk Management
A&M System Building
200 Technology Way
Suite 1120
Mail Stop 1262 TAMU
College Station, Texas 77845-3424
kball@tamu.edu
www.tamus.edu

979.458.6330
979.458.6247 fax

MEDICAL SERVICES CHART

CLAIM# 211-013423

CLAIMANT_

DOI: 11/5/10 Nature of injury laceration/trauma

Body Part Injured Rt. Index finger/Phalanx

MMI DATE_____ %IMPAIRMENT_____

Treating Dr _____

Approved Change_____

Consulting/Referral (approval date)

_____

_____

RME_____ Date_____

Result_____

D/D _____ Date_____

Result_____

Initial Treatment Plan **Initial Diagnosis Code**_____

Secondary Treatment Plan or Changes

X-Ray

Body Part_____ Date_____ Result_____

MRI

Body Part_____ Date_____ Result_____

C/T Scan

Body Part_____ Date_____ Result_____

Bone Scan

Body Part_____ Date_____ Result_____

Myelogram

Body Part_____ Date_____ Result_____

EMG

Body Part_____ Date_____ Result_____

PHYSICAL THERAPY

WEEK 1_____	WEEK 1_____
WEEK 2_____	WEEK 2_____
WEEK 3_____	WEEK 3_____
WEEK 4_____	WEEK 4_____
WEEK 5_____	WEEK 5_____
WEEK 6_____	WEEK 6_____
WEEK 7_____	WEEK 7_____
WEEK 8_____	WEEK 8_____

COMMENTS:_____

SURGICAL PROCEDURES

_____ Date_____

_____ Date_____

_____ Date_____

_____ Date_____

_____ Date_____

DENIED PHARMACY

PREAUTHORIZATIONS

DATE	YES/NO	PROCEDURE

BODY PART DENIED_____

DATE_____ TWCC 21 FILED Y/N

BODY PART DENIED_____

DATE_____ TWCC 21 FILED Y/N

BODY PART DENIED_____

DATE_____ TWCC 21 FILED Y/N

NOTES:_____

Injury Date: 11/15/2010 Service Date: 12/23/2010

Invoice # 1056 Date of Invoice: 01/03/2011 211-0134-083 KB

DEMOGRAPHICS: is a 25 year-old female, who works as a full time Research Assistant for TAMU.

CHIEF COMPLAINT: Pt states she cut her finger with a scalpel while cleaning up after a goat necropsy. Goat was positive for Brucella encapsulated delta VJBR 10 to the sixth.

HISTORY OF PRESENT ILLNESS: primary problem is a laceration located in the right index finger, pip joint. She describes it as small. She considers it to be resolved. It has been about 5 weeks since the onset of the a laceration. Her pain level is 0/10.

REVIEW OF SYSTEMS:

Constitutional: Negative for chills, fever.

Eyes: Negative for jaundice.

ENT: Negative for bleeding gums, swollen lymph nodes, nose bleeds.

Cardiovascular: Negative for heart murmur.

Respiratory: Negative for asthma.

Gastrointestinal: Negative for history of hepatitis.

Genitourinary: Negative for frequent urination.

Musculoskeletal: Negative for joint pain.

Skin and Breast: Negative for skin laceration, bruises on right hand.

Neurological: Negative for seizures.

Psychiatric: Negative for depression.

Endocrine: Negative for diabetes.

Hematologic: Negative for takes aspirin, takes anti-coagulants.

Immunologic: Negative for cancer chemotherapy, frequent infections, intravenous drug use, swollen lymph nodes.

PAST, FAMILY AND SOCIAL HISTORY:

Tetanus Immunization: She states she had her last tetanus immunization 11/15/2010 at her primary care physician's office.

CURRENT MEDICATIONS: Yasmin 28, Zoloft, Alegra and Nasonex.

ALLERGIES: Protussus vaccine, Cephaloporins and Topamax.

VITAL SIGNS: Weight: 136.6 lbs. Height: 62.5 inches. BMI: 24.6 (Normal). Blood Pressure: 110/72. Respiratory Rate: 16/min and normal. Pulse Rate: 78/min.

Injury Date: 11/15/2010 Service Date: 12/23/2010

Invoice # 1056 Date of Invoice: 01/03/2011

211-0134-23KR3

EXAMINATION:

Chest: The chest examination is normal.

Lungs: The lung examination is normal.

DIAGNOSIS: 1. Other & unspecified superficial injury of finger with out infections (915.8). 2. Infectious Disease, Exposure (V01.9).

DISCUSSION: Brucella Antibody Titer today per CDC guidelines. Patient states she took Doxicycline100 mg po bid and Rifampin 600 mg po QD for 10 days and was unable to complete the entire antibiotic treatment due to it making her dizzy and nauseated.

PLAN OF CARE: The reason for discharge was completion of treatment plan. Brucella antibody titer today CDC guidelines.

PRESCRIPTIONS: ' has been prescribed the following:

RX #1: None.

She has been instructed in medication use and side effects.

MEDICAL CAUSATION: The cause of this problem is related to work activities.

RECOMMENDED WORK STATUS: recommended work status is regular duty. The effective date for this work status is 11/15/2010. This work status designation ends 12/23/2010.

RECOMMENDED ACTIVITY RESTRICTIONS:

None.

AFTERCARE INSTRUCTIONS: Contact us if you have any questions or problems.

Nicole L. Kroll, RN ANP-C

Employee - You are required to report your injury to your employer within 30 days or your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(800)-252-7031.

Empleado - Es necesario que reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que se lesionó si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte de la División de Compensación para Trabajadores, y también puede tener derecho a ciertos beneficios médicos y monetarios. Para mayor información comuníquese con la oficina local de la División al teléfono 1-800-252-7031.

REPORT OF MEDICAL EVALUATION

CLAIM #: 11-0134-23KB

PART I: GENERAL INFORMATION

1. Workers' Compensation Insurance Carrier:

2. Employer's Name: Texas A&M University Systems

3. Employer's Address: 200 Technology Wny. Suite 1120
City: College Station, State: TX, Zip: 77845

4. Injured Employee's Name (Last, First, MI):

5. Date of Injury: 11/15/2010

6. Social Security Number:

7. Employee's Phone #:

8. Employee's Address:
City: State: Zip:

9. Certifying Doctor's Name and Licensure: Dr. Eric Wilke M.D. L0697

10. Certifying Doctor's License Number and Jurisdiction: L0697 TX

11. Certifying Doctor's Phone & Fax #: (Ph) (979) 680-9675 (Fax) (979) 845-8650

12. Certifying Doctor's Address: 1605 Rock Prairie Road, Suite 100
City: College Station, State: TX, Zip: 77845

PART II: DOCTOR'S ROLE AND CERTIFICATION

13. Indicate which role you are serving in the claim in performing this evaluation. Only a doctor serving in one of the following roles is authorized to evaluate MMI/impairment and file this report (Workers' Compensation Rule 130.1 governs such authorization):

☑ Treating Doctor ☐ Doctor Selected by Treating Doctor acting in place of the Treating Doctor ☐ Designated Doctor Selected by the Division

☐ Carrier-Selected RME Doctor approved by the Division to evaluate MMI and/or permanent impairment after a Designated Doctor examination.

NOTE – If you are not authorized by Rule 130.1 to file this report, you will not be paid for this report or the MMI/impairment examination.

14. I HEREBY CERTIFY THAT THIS REPORT OF MEDICAL EVALUATION is complete and accurate and complies with the Texas Workers' Compensation Act and applicable rules, and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature of Certifying Doctor: Eric Wilke MD Date of Certification: 12/23/2010

PART III: MEDICAL STATUS INFORMATION

15. Date of Exam: 12/23/2010

16. Diagnosis (ICD-9 Codes): 1) 915.8 2) V01.9 3) 4)

17. Indicate whether the employee has reached Clinical or Statutory MMI based upon the following definitions:

Clinical Maximum Medical Improvement (Clinical MMI) is the earliest date after which, based upon reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated.

Statutory MMI is the later of: (1) the end of the 104th week after the date that temporary income benefits (TIBs) began to accrue; or (2) the date to which MMI was extended by the Division through operation of Texas Labor Code §408.104.

a) ☑ Yes, I certify that the employee reached ☐ STATUTORY / ☑ CLINICAL (mark one) MMI on 12/23/2010 (may not be a prospective date) and have included documentation relating to this certification in the attached narrative. OR

b) ☐ No, I certify that the employee has NOT reached MMI but is expected to reach MMI on or about _____. The reason the employee has not reached MMI is documented in the attached narrative.

NOTE – The fact that an employee reaches either Clinical MMI or Statutory MMI does not signify that the employee is no longer entitled to medical benefits.

PART IV: PERMANENT IMPAIRMENT

18. If the employee has reached MMI, indicate whether the employee has permanent impairment as a result of the compensable injury.

"Impairment" means any anatomic or functional abnormality or loss existing after MMI that results from a compensable injury and is reasonably presumed to be permanent. The finding that impairment exists must be made based upon objective clinical or laboratory findings meaning a medical finding of impairment resulting from a compensable injury, based upon competent objective medical evidence that is independently confirmable by a doctor, including a designated doctor, without reliance on the subjective symptoms perceived by the employee.

a) ☑ I certify that the employee does not have any permanent impairment as a result of the compensable injury. OR

b) ☐ I certify that the employee has permanent impairment as a result of the compensable injury. The amount of permanent impairment is _____%, which was determined in accordance with the requirements of the Texas Workers' Compensation Act and Workers' Compensation Rules. The attached narrative provides documentation involved in the calculation of the impairment rating assigned using the following edition of the Guides to the Evaluation of Permanent Impairment published by the American Medical Association (AMA): ☐ third edition, second printing, February 1989. OR ☐ fourth edition, 1st, 2nd, 3rd, or 4th printing, including corrections and changes issued by the AMA prior to May 18, 2000.

PART V: TREATING DOCTOR'S AGREEMENT OR DISAGREEMENT WITH ANOTHER DOCTOR'S CERTIFICATION

19. Treating Doctor's Name and Degree: Dr. Eric Wilke M.D. L0697

20. Treating Doctor's License Number and Jurisdiction: L0697 TX

21. Treating Doctor's Phone & Fax #: (Ph) (979) 680-9675 (Fax) (979) 845-8650

22. ☐ I AGREE / ☐ I DISAGREE with the certifying doctor's certification of MMI.

23. ☐ I AGREE / ☐ I DISAGREE with the certifying doctor's finding of no impairment. OR
☐ I AGREE / ☐ I DISAGREE with the impairment rating assigned by the certifying doctor.

24. I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature of Treating Doctor: Eric Wilke MD Date: 12/23/2010

NOTE: With few exceptions, you are entitled by law to know, review, and correct information that DWC collects on its forms about you. For more information, call our Open Records section at 512-804-4437.

NOTA: Usted tiene derecho por ley de saber, revisar y corregir información que la División ha recogido en sus formularios con algunas excepciones. Para mayor información llame a la sección de archivo abierto "Open Records" al teléfono 512-804-4437.

DIVISION OF WORKERS' COMPENSATION

DEMOGRAPHICS: is a 25 year-old female, who works as a full time Research Assistant for TAMU.

CHIEF COMPLAINT: Pt states she cut her finger with a scalpel while cleaning up after a goat necropsy. Goat was positive for Brucella encapsulated delta VJBR 10 to the sixth.

HISTORY OF PRESENT ILLNESS: primary problem is a laceration located in the right index finger, pip joint. She describes it as small. She considers it to be minimal. It has been less than a day since the onset of the a laceration. She feels it is stable. Her pain level is 0/10.

REVIEW OF SYSTEMS:

Constitutional: Negative for chills, fever.

Eyes: Negative for jaundice.

ENT: Negative for bleeding gums, swollen lymph nodes, nose bleeds.

Cardiovascular: Negative for heart murmur.

Respiratory: Negative for asthma.

Gastrointestinal: Negative for history of hepatitis.

Genitourinary: Negative for frequent urination.

Musculoskeletal: Negative for joint pain.

Skin and Breast: POSITIVE for skin laceration. Negative for bruises on right hand.

Neurological: Negative for seizures.

Psychiatric: Negative for depression.

Endocrine: Negative for diabetes.

Hematologic: Negative for takes aspirin, takes anti-coagulants.

Immunologic: Negative for cancer chemotherapy, frequent infections, intravenous drug use, swollen lymph nodes.

PAST, FAMILY AND SOCIAL HISTORY:

Tetanus Immunization: She states she had her last tetanus immunization today 11/15/2010 at her primary care physician's office.

CURRENT MEDICATIONS: Yasmin 28 and Zoloft.

ALLERGIES: Protussus vaccine, Cephaloporins and Topamax.

VITAL SIGNS: Weight: 132 lbs. Height: 62.5 inches. BMI: 23.8 (Normal). Blood Pressure: 104/70. Respiratory Rate: 12/min and normal. Pulse Rate: 88/min.

211-0134-23 RB

EXAMINATION:

Right Hand: A small 1 cm superficial laceration is present over the right index finger PIP joint. Bruising is not present. Erythema is not present. Wound is open, no bleeding at this time. Pain on motion is not present. Pain to palpation is not present. A rash is not present. Swelling is not present. Range of motion is normal. Strength is normal.

Chest: The chest examination is normal.

Lungs: The lung examination is normal.

DIAGNOSIS: 1. Other & unspecified superficial injury of finger with out infections (915.8). 2. Infectious Disease, Exposure (V01.9).

DISCUSSION: Brucella Antibody Titer today and in 6 weeks per CDC guidelines. Patient to start Doxicycline100 mg po bid and Rifampin 600 mg po QD for 21 days.

PLAN OF CARE: Follow up visit in 7-10 days unless fever, swelling redness or discharge from laceration. Brucella antibody titer today and in 6 weeks per CDC guidelines.

MEDICAL CAUSATION: The cause of this problem is related to work activities.

RECOMMENDED WORK STATUS: recommended work status is regular duty. The effective date for this work status is 11/15/2010.

RECOMMENDED ACTIVITY RESTRICTIONS:

None.

AFTERCARE INSTRUCTIONS: Return here for your follow-up visit in 7 days. Your prescription will be call in to the pharmacy. Call us if you have redness, swelling or drainage. Keep all wounds clean and dry. Follow up in 6 weeks for 2nd Brucella Titer per CDC guidelines.

Nicole L. Kroll, RN ANP-C

CERTIFIED MAIL™

The Texas A&M University System
Office of Risk Management and Safety
A&M System Building, Suite 1120
200 Technology Way
College Station, Texas 77845-3424

7009 1680 0001 0282 2[illegible]

UNITED STATES POSTAGE PITNEY BOWES
02 1M $ 05.54⁰
0004273026 JAN 13 2011
MAILED FROM ZIP CODE 77845

Resent by regular mail. LR 1-14-11 BB

NIXIE 773 DE 1 00 02/03/11
RETURN TO SENDER
UNCLAIMED
UNABLE TO FORWARD
BC: 77845342400 *2199-07439-13-39

7784533424 77845342424

Hammond SO -11-012-013
TAMUS 0052

WORKERS' COMPENSATION
INITIAL STATUS OF CLAIM REPORT

To:	**Matt Walton**	Date:	**11/23/2010**
	TAM-HSC	RE:	
		Employed By	**TAM-HSC**
		Supervisor:	**Allison Ficht**
		D.O.I.:	**11/15/2010**
		Claim No.:	**211-0134-23**

PLEASE USE THE INFORMATION BELOW AS YOU DEEM NECESSARY

☐ We have received a medical bill/report that indicates an injury may have occurred on . Please verify with your records. If an injury occurred forward a copy of the Employer's First Report of Injury or your incident/accident report so we may timely process the medical bill. If an injury has not been reported, please notify this office, in writing, as soon as possible. ***If a response is not received within 3 days of receipt of this notice the claim for compensability will be accepted.***

☐ The employer's First Report of Injury has been received. Weekly compensation benefits will begin after the seven day waiting period pursuant to the Texas Workers' Compensation Act if disability continues **unless a Supplemental Report of Injury is received indicating the employee has returned to work or unless the Request for Paid Leave is received indicating that the employee will use sick and or annual leave.** A wage statement is required if the employee is disabled for more than eight days, even if the employee is using sick/annual leave of FMLA leave.

☒ This claim has been accepted as a compensable injury.

☐ This is a questionable claim. However, sufficient evidence does not exist at this time to contest compensability. Please provide us with written witness statements, and any other objective information that would assist us in making a determination of compensability.

☐ This claim has been denied because:
- ☐ There was no injury in course and scope of employment
- ☐ The injury was not sustained in the course & scope of employment
- ☐ Untimely notice of injury was given
- ☐ The injury is considered an ordinary disease of life
- ☐ Disability only, medical documentation required to establish physical harm
- ☐ Other:

☐ Other:
Thanks.

Please direct any questions regarding this claim and the above information to:

The Texas A&M University System
Office of Risk Management & Safety
College Station, TX 77845-3424
Phone: 979/458-6330 Fax: 979/458-6247

Adjuster: Kaye Ball
F:wci,procedure;office

TAMUS DEPT VOUCHER NO 261010# 73445

STATE OF TEXAS PURCHASE VOUCHER

Agency
TEXAS A&M UNIVERSITY SYSTEM
College Station,TX 77840

Agency Voucher No

Order Date: 03/16/2011
Requisition No: NONE
Invoice Date: 03/16/2011
Voucher Amount: $79.35
Payee Reference No: NONE
Control No: NONE

Comptroller Vendor ID No: 1621762360 NONE

Pay To (Name, Address, City, State, Zip)
CS MEDICAL CENTER OCCUPATIONAL MEDICINE
1605 ROCK PRAIRIE RD
SUITE 100
COLLEGE STATION, TX 77845

Agency Object	Amount
6462	$79.35 E N C

Account Name: Workers's Compensations Ins.

TOTAL: $79.35

ENCUMBRANCE LEDGER

Requisition No	Amount

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	Amount
12/23/2010 - 12/23/2010	211013423	$79.35

VENDOR CERTIFICATION
(Use when no invoice is available)
I certify the described articles or services were contracted for and the account is true,correct and unpaid.

SIGNATURE

AGENCY CERTIFICATION
I certify that the above services were rendered,or goods received and that they correspond in every particular with contract under which they were procured and that the invoice is true and unpaid

DATE APPROVED FOR PAYMENT

NAME (PERSON RECEIVING GOODS) DATE 03/16/2011

NAME (DEPT HEAD) DATE 03/16/2011

NAME

TITLE

DWC #

Carrier's Claim # 211013423

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of injury
		11/15/2010

4. Injured employee's mailing address (Street or P.O. Box)	5. Employer's name and address
	TAMUS HEALTH SCIENCE CENTER JOHN B CONNALLY BUILDING 301 TARROW STREET 6TH FL COLLEGE STATION, TX 77840
6. Health care provider's name and address CS MEDICAL CENTER OCCUPATIONAL MEDICINE 1605 ROCK PRAIRIE RD SUITE 100 COLLEGE STATION, TX 77845	7. Insurance carrier's name and address The Texas A&M University System 200 Technology Way, Suite 1120 College Station, TX 77845
8. Health care provider's federal tax I.D. number 621762360	Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s). Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act. ITN Number: 00454133
9. Name and address of the company performing the audit Starr Comprehensive Solutions, Inc. P.O. Box 801464 Houston, TX 77280-1464	
Date of the audit: 03/13/2011	
10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc. Phone: 866-462-4197 Fax: 713-462-4143	

ICD9 Codes used: 915.8 - OTHER AND UNSPECIFIED SUPERFICIAL INJURY OF FINGERS WITHOUT INFECTION
V01.9 - CONTACT WITH OR EXPOSURE TO UNSPECIFIED COMMUNICABLE DISEASE

Dates of Service From Date	Thru Date	Procedure Code and Description	Modifier	Units	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
12/23/2010	12/23/2010	99212		1.00	$60.00	$56.91	$0.00	$56.91	W1
		OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: PROB FOCUS HX; PROB FOCUS EXAM; STRTF							
12/23/2010	12/23/2010	86622		1.00	$17.00	$17.00	$0.00	$17.00	
		ANTIBODY; BRUCELLA							
12/23/2010	12/23/2010	36415		1.00	$10.00	$5.44	$0.00	$5.44	W1
		COLLECTION, VENOUS BLOOD, VENIPUNCTURE							
				Totals:	$87.00	$79.35	$0.00	$79.35	

Reason for Reduction or Denial:
W1 - Workers Compensation State Fee Schedule Adjustment

RECEIVED
2011 MAR 16 AM 10:01
TAMUS
OFFICE OF RISK MANAGEMENT

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Texas A&M University Systems
Deanna Holladay
200 Technology Way
Suite 1120
College Station, TX 77845-

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID) X
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY	SEX M / F X	4. INSURED'S NAME (Last Name First Name Middle Initial) Texas A&M University Systems		
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT'S RELATIONSHIP TO INSURED Self / Spous / Child / Othe X		7. INSURED'S ADDRESS (No. Street) 200 Technology Way		
CITY	STATE	8. PATIENT STATUS Employe / Full-Tim e / Part-Tim e / Student		CITY College Station	STATE TX	
ZIP CODE 77845	TELEPHONE (Include Area Code) (979)			ZIP CODE 77845	TELEPHONE (INCLUDE AREA CODE) (979) 458-6330	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) NONE		10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER		
a. OTHER INSURED'S POLICY OR GROUP NUMBER NONE 211-0134-23103		a. EMPLOYMENT? (CURRENT OR PREVIOUS) X YES / NO		a. INSURED'S DATE OF BIRTH MM DD YY	SEX M / F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY	SEX M / F	b. AUTO ACCIDENT? YES / X NO	PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME		
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? YES / X NO		c. INSURANCE PLAN NAME OR PROGRAM NAME		
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / X NO If yes, return to and complete item 9		

RECEIVED 01 MAR -7 PM 0[illegible] TAMUS RISK MANAGEMENT

READ BACK FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SOF DATE 01 03 2011

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SOF

14. DATE OF CURRENT: MM DD YY 11 15 10 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a / 17b NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. RESERVED FOR LOCAL USE		20 OUTSIDE LAB? YES / X NO	$ CHARGES 0 00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 915 8 Other and unspecified superficial injury; 2. V01 9 Contact with or exposure to; unspecified; 3. ; 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF NO	
		23. PRIOR AUTHORIZATION NUMBER	

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C EMG	D PROCEDURES, SERVICES, OR (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUA	J RENDERING PROVIDER ID #
1 ZZOV Established, Expanded 12 23 10	12 23 10	11		99212		1,2	60 00	1.00		WJ	56.91 1508877267
2 ZZBrucella Antibody (Titer) 12 23 10	12 23 10	11		86622		1,2	17 00	1.00		NPI	17.09 1508877267
3 ZZBlood Collection Only 12 23 10	12 23 10	11		36415		1,2	10 00	1.00		WJ	5.44
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER 621762360	SSN / EIN X	26. PATIENT'S ACCOUNT NO Inv # 1056	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES / NO	28. TOTAL CHARGE $ 87 00	29. AMOUNT PAID $ 79 35	30. BALANCE DUE $ 87 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED 01 03 2011 DATE

32. SERVICE FACILITY LOCATION INFORMATION (979) 680-9675
CS Medical Center Occupational Medicine
1605 Rock Prairie Road
Suite 100
College Station TX 77845
a. 1467403477 b. EI621762360

33. BILLING PROVIDER INFO & PH # (979) 680 9675
CS Medical Center Occupational Medicine
1605 Rock Prairie Rd
Suite 100
College Station, TX 77845
a. 1467403477 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500

SYSTOC v7.27 O:\REPORTS\BILLING\1500 CLAIM FORM <h>v7.27#088

TAMUS DEPT VOUCHER NO 261010# 70485

STATE OF TEXAS PURCHASE VOUCHER

Agency TEXAS A&M UNIVERSITY SYSTEM College Station,TX 77840		Order Date 12/21/2010	Agency Voucher No Requisition No NONE
	Invoice Date 12/21/2010	Voucher Amount $144.57	Payee Reference No NONE
			Control No NONE

Comptroller Vendor ID No 1621762360 NONE	Agency Object	Amount
Pay To (Name, Address, City, State, Zip) CS MEDICAL CENTER OCCUPATIONAL MEDICINE 1605 ROCK PRAIRIE RD SUITE 100 COLLEGE STATION, TX 77845	6462	$144.57 E N C
Account Name Workers's Compensations Ins.		TOTAL $144.57

ENCUMBRANCE LEDGER	
Requisition No	Amount

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	Amount
11/15/2010 - 11/15/2010	211013423	$144.57

VENDOR CERTIFICATION
(Use when no invoice is available)
I certify the described articles or services were contracted for and the account is true,correct and unpaid.

SIGNATURE

AGENCY CERTIFICATION
I certify that the above services were rendered,or goods received and that they correspond in every particular with contract under which they were procured and that the invoice is true and unpaid

DATE APPROVED FOR PAYMENT

NAME (PERSON RECEIVING GOODS)	DATE	12/21/2010	NAME
NAME (DEPT HEAD)	DATE	12/21/2010	TITLE

DWC #

Carrier's Claim # 211013423

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of injury
		11/15/2010

4. Injured employee's mailing address (Street or P.O. Box)

5. Employer's name and address
TAMUS HEALTH SCIENCE CENTER
JOHN B CONNALLY BUILDING 301 TARROW STREET 6TH FL
COLLEGE STATION, TX 77840

6. Health care provider's name and address
CS MEDICAL CENTER OCCUPATIONAL MEDICINE
1605 ROCK PRAIRIE RD SUITE 100
COLLEGE STATION, TX 77845

7. Insurance carrier's name and address
The Texas A&M University System
200 Technology Way, Suite 1120
College Station, TX 77845

8. Health care provider's federal tax I.D. number
621762360

9. Name and address of the company performing the audit
Starr Comprehensive Solutions, Inc.
P.O. Box 801464
Houston, TX 77280-1464

Date of the audit: 12/17/2010

10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc.
Phone: 866-462-4197 Fax: 713-462-4143

Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s).

Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act.

ITN Number: 00429063

ICD9 Codes used: 915.8 - OTHER AND UNSPECIFIED SUPERFICIAL INJURY OF FINGERS WITHOUT INFECTION
V01.9 - CONTACT WITH OR EXPOSURE TO UNSPECIFIED COMMUNICABLE DISEASE

Dates of Service From Date	Thru Date	Procedure Code and Description	Modifier	Units	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)	
11/15/2010	11/15/2010	99203		1.00	$130.00	$122.13	$0.00	$122.13	W1	
		OFFICE/OP VISIT, NEW PT, 3 KEY COMPONENTS: DETAILED HX; DETAILED EXAM; MED DECIS								
11/15/2010	11/15/2010	86622		1.00	$17.00	$17.00	$0.00	$17.00		
		ANTIBODY; BRUCELLA								
11/15/2010	11/15/2010	99080		1.00	$15.00	$0.00	$0.00	$0.00	97	4
		SPECIAL REPORTS/INSURANCE FORMS							16	
11/15/2010	11/15/2010	36415		1.00	$10.00	$5.44	$0.00	$5.44	W1	
		COLLECTION, VENOUS BLOOD, VENIPUNCTURE								
				Totals:	$172.00	$144.57	$0.00	$144.57		

Reason for Reduction or Denial:
W1 - Workers Compensation State Fee Schedule Adjustment
97 - Payment is included in the allowance for another service/procedure
4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.
16 - Documentation does not support billed services

Comments:
DOCUMENTATION DOES NOT SUPPORT THAT THIS CLAIMANT WAS SEEN AND EVALUATED BY A PHYSICIAN PRIOR TO THE EVALUATION BY THE PA-C. THEREFORE, THE REQUIREMENTS FOR "INCIDENT TO" HAVE NOT BEEN MET. REIMBURSEMENT IS 85% OF PHYSICIAN FEE.

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

97 - Reports are global of evaluation and management services. No modifiers used.

4 - Modifier - 73 required when billing work status report.

16 - DOCUMENTATION SUBMITTED DOES NOT SUPPORT BILLING. NO WORK STATUS FORM PROVIDED.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

Texas A&M University Systems
Deanna Holladay
200 Technology Way
Suite 1120
College Station, TX 77845-

PICA

1. MEDICARE ☐ (Medicare) MEDICAID ☐ (Medicaid) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☒ (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle I)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M ☐ F ☒	4. INSURED'S NAME (Last Name, First Name, Middle Initial) ~~Texas A&M University Systems~~ HSC
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT'S RELATIONSHIP TO INSURED Self ☐ Spous ☐ Child ☐ Othe ☒	7. INSURED'S ADDRESS (No., Street) ~~200 Technology Way~~
CITY / STATE	8. PATIENT STATUS Employe ☐ Full-Time ☐ Part-Time ☐ Student	CITY College Station / STATE TX
ZIP CODE 77845 / TELEPHONE (Include Area Code) (979)		ZIP CODE 77845 / TELEPHONE (INCLUDE AREA CODE) (979) 458 6330
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) NONE	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER NONE 211-0934-23KRB	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☒ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, return to and complete item 9

READ BACK FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SOF DATE 12 06 2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SOF

14. DATE OF CURRENT: MM DD YY 11 15 10 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. / 17b NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☒ NO / $ CHARGES 0 00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 915 8 Other and unspecified superficial injury; 2. V01 9 Contact with or exposure to; unspecified; 3. ; 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C EMG	D PROCEDURES, SERVICES, OR (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUA	J RENDERING PROVIDER ID. #
1 ZZOV New, Detailed: 11 15 10 / 11 15 10	11		99203		1,2	130 00	1.00		NPI	1508877267
2 ZZBrucella Antibody (Titer): 11 15 10 / 11 15 10	11		86622		1,2	17 00	1.00		NPI	1508877267
3 ZZDWC 73: 11 15 10 / 11 15 10	11		99080		1,2	15 00	1.00		NPI	1508877267
4 ZZBlood Collection Only: 11 15 10 / 11 15 10	11		36415		1,2	10 00	1.00		NPI	5.44
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER 621762360 SSN ☐ EIN ☒	26. PATIENT'S ACCOUNT NO Inv # 1039	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO	28. TOTAL CHARGE $ 172 00	29. AMOUNT PAID $ 44.56	30. BALANCE DUE $ 172 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED 12 06 2010 DATE	32. SERVICE FACILITY LOCATION INFORMATION (979) 680-9675 CS Medical Center Occupational Medicine 1605 Rock Prairie Road Suite 100 College Station TX 77845 a 1467403477 b EI621762360		33. BILLING PROVIDER INFO & PH # (979) 680 9675 CS Medical Center Occupational Medicine 1605 Rock Prairie Rd Suite 100 College Station, TX 77845 a 1467403477 b. 12 21 10 DD		

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500

SYSTOC v7.27_O:\REPORTS\BILLING\1500 CLAIM FORM_<b>v7.27#088

Hammond SO -11-012-013
TAMUS 0060

TAMUS DEPT VOUCHER NO 261010# 70211

STATE OF TEXAS PURCHASE VOUCHER

Agency TEXAS A&M UNIVERSITY SYSTEM College Station,TX 77840			Order Date 12/16/2010	Agency Voucher No Requisition No NONE
	Invoice Date 12/16/2010	Voucher Amount $105.50	Payee Reference No NONE	Control No NONE

Comptroller Vendor ID No 1621770924 NONE	Agency Object	Amount
Pay To (Name, Address, City, State, Zip) STONERIVER - PHARMACY SOLUTIONS P.O. BOX 100994 ATLANTA, GA 30384-0994	6462	$105.50 E N C
Account Name Workers's Compensations Ins.	TOTAL	$105.50

ENCUMBRANCE LEDGER	
Requisition No	Amount

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	Amount
11/19/2010 - 11/19/2010	211013423	$105.50

VENDOR CERTIFICATION
(Use when no invoice is available)
I certify the described articles or services were contracted for and the account is true,correct and unpaid.

SIGNATURE

AGENCY CERTIFICATION
I certify that the above services were rendered,or goods received and that they correspond in every particular with contract under which they were procured and that the invoice is true and unpaid

DATE APPROVED FOR PAYMENT

NAME (PERSON RECEIVING GOODS)	DATE	12/16/2010	NAME
NAME (DEPT HEAD)	DATE	12/16/2010	TITLE

DWC #
Carrier's Claim # 211013423

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of injury
		11/15/2010

4. Injured employee's mailing address (Street or P.O. Box)	5. Employer's name and address
	TAMUS HEALTH SCIENCE CENTER JOHN B CONNALLY BUILDING 301 TARROW STREET 6TH FL COLLEGE STATION, TX 77840
6. Health care provider's name and address STONERIVER - PHARMACY SOLUTIONS P.O. BOX 100994 ATLANTA, GA 30384-0994	7. Insurance carrier's name and address The Texas A&M University System 200 Technology Way, Suite 1120 College Station, TX 77845
8. Health care provider's federal tax I.D. number 621770924	Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s). Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act. ITN Number: 00426517
9. Name and address of the company performing the audit Starr Comprehensive Solutions, Inc. P.O. Box 801464 Houston, TX 77280-1464	
Date of the audit: 12/08/2010	
10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc. Phone: 866-462-4197 Fax: 713-462-4143	

Date / Product/Strength	Rx. #	NDC #	Day Supply	Which Refill #	Generic Drug	Quantity / Doctor	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
11/19/2010 RIFAMPIN/300 MG	68779	00527131530	21	0	Yes	42.00 ERIC WILKE	$105.50	$105.50	$0.00	$105.50	
						Totals:	**$105.50**	**$105.50**	**$0.00**	**$105.50**	

RECEIVED
2010 DEC 16 PM 2:09
TAMUS
OFFICE OF RISK MANAGEMENT

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

00161 7771569 003101 003101 00009-00025

TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION STATEMENT OF PHARMACY SERVICES

Send this form to the injured employee's workers' compensation insurance carrier.

Coverage Verification

☒ In accordance with Rule 134.501, I affirm that I have verified the workers' compensation insurance coverage for this employer, confirmed that a work-related injury of the employee named below has been reported to the employer for the listed date of injury, and have kept documentation regarding the means of verification/confirmation on file. (See DCW FORM-66 instructions for the Verification Statement.)

Section 1

1. Pharmacy's Name, Address, and Phone #:
KROGER PHARMACY
3535 LONGMIRE DR
COLLEGE STATION, TX 77845-5271
Phone (979) 485-8813
Fax

2. Date of Billing:
11/28/10

3. Pharmacy's NCPDP #: (NPI #):
4515120 1962575480

4. Remit Payment To (If different from above):
StoneRiver - Pharmacy Solutions
P.O. BOX 100994
ATLANTA, GA 30384-0994

5. Invoice #:
34077388

6. Payee's FEIN:
62-1770924

7. Carrier's Name and Address:
TEXAS A & M UNIVERSITY SYSTEM
ATTN: kay ball
200 TECHNOLOGY WAY STE 1120
COLLEGE STATION, TX 77845-3424

8. Employer's Name, Address, and Phone #:
TEXAS A&M
332 WERC
COLLEGE STATION, TX 77843
(979) 845-3211

9. Injured Employee's Name, Address, and Phone #:

15. Prescribing Doctor's Name, Address, and Phone #:
WILKE ERIC MD
300 KRENEK TAP RD
COLLEGE STATION, TX 77845-9023
(979) 764-5100

10a. Injured Employee's ID #

10b. ID Jurisdiction
U.S.

10c. ☒ SSN ☐ DL# ☐ Passport ☐ Visa ☐ Green Card

16. Prescribing Doctor's DEA#: (NPI #):
FW0401163 1578591199

11. DOI:
11/15/10

12. DOB:
5

13. Claim # (if known):

14. Carrier's Claim # (if known):
211013423

RECEIVED
2010 DEC -6 AM 11:09
TEXAS DEPARTMENT OF INSURANCE
RISK MANAGEMENT

Section 2

17.	18.	19.	20.	21.	22.	23.	24.	25.	26.	27.	28.	29.
☒ Generic Dispensed ☐ Name Brand Dispensed	Generic Available? ☐ YES ☐ NO	☐ Dispensed as Written ☐ Dispensed per Injured Employee request	Date filled:	Generic NDC:	Name Brand NDC:	Quantity:	Days Supply:	Refills Remaining:	Paid by Employee:	Drug Name and Strength:	Rx #:	Amount Billed:
			11/19/10	00527131530		42	21	0		RIFAMPIN CAP 300MG	6877966	105.50

17.	18.	19.	20.	21.	22.	23.	24.	25.	26.	27.	28.	29.
☐ Generic Dispensed ☐ Name Brand Dispensed	Generic Available? ☐ YES ☐ NO	☐ Dispensed as Written ☐ Dispensed per Injured Employee request	Date filled:	Generic NDC:	Name Brand NDC:	Quantity:	Days Supply:	Refills Remaining:	Paid by Employee:	Drug Name and Strength:	Rx #:	Amount Billed:

17.	18.	19.	20.	21.	22.	23.	24.	25.	26.	27.	28.	29.
☐ Generic Dispensed ☐ Name Brand Dispensed	Generic Available? ☐ YES ☐ NO	☐ Dispensed as Written ☐ Dispensed per Injured Employee request	Date filled:	Generic NDC:	Name Brand NDC:	Quantity:	Days Supply:	Refills Remaining	Paid by Employee	Drug Name and Strength:	Rx #:	Amount Billed

INVOICE # 34077388 TOTAL 105.50
12/16/10 DN

TAMUS DEPT VOUCHER NO 261010# 70210

STATE OF TEXAS PURCHASE VOUCHER

Agency TEXAS A&M UNIVERSITY SYSTEM College Station,TX 77840			Agency Voucher No	
		Order Date 12/16/2010	Requisition No NONE	
	Invoice Date 12/16/2010	Voucher Amount $64.90	Payee Reference No NONE	Control No NONE
Comptroller Vendor ID No 1621770924	NONE		Agency Object 6462	Amount $64.90 E N C
Pay To (Name, Address, City, State, Zip) STONERIVER - PHARMACY SOLUTIONS P.O. BOX 100994 ATLANTA, GA 30384-0994				
Account Name Workers's Compensations Ins.			TOTAL $64.90	

ENCUMBRANCE LEDGER	
Requisition No	Amount

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	Amount
11/15/2010 - 11/15/2010	211013423	$64.90

VENDOR CERTIFICATION
(Use when no invoice is available)
I certify the described articles or services were contracted for and the account is true,correct and unpaid.

SIGNATURE

AGENCY CERTIFICATION
I certify that the above services were rendered,or goods received and that they correspond in every particular with contract under which they were procured and that the invoice is true and unpaid

DATE APPROVED FOR PAYMENT

NAME (PERSON RECEIVING GOODS)	DATE	12/16/2010	NAME	
NAME (DEPT HEAD)	DATE	12/16/2010	TITLE	

DWC #

Carrier's Claim # 211013423

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of injury
		11/15/2010

4. Injured employee's mailing address (Street or P.O. Box)	5. Employer's name and address
	TAMUS HEALTH SCIENCE CENTER JOHN B CONNALLY BUILDING 301 TARROW STREET 6TH FL COLLEGE STATION, TX 77840
6. Health care provider's name and address STONERIVER - PHARMACY SOLUTIONS P.O. BOX 100994 ATLANTA, GA 30384-0994	7. Insurance carrier's name and address The Texas A&M University System 200 Technology Way, Suite 1120 College Station, TX 77845
8. Health care provider's federal tax I.D. number 621770924	Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s). Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act. ITN Number: 00426514
9. Name and address of the company performing the audit Starr Comprehensive Solutions, Inc. P.O. Box 801464 Houston, TX 77280-1464	
Date of the audit: 12/08/2010	
10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc. Phone: 866-462-4197 Fax: 713-462-4143	

Date	Rx. #	NDC #	Day Supply	Which Refill #	Generic Drug	Quantity	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
Product/Strength						Doctor					
11/15/2010	68779	53489011905	21	0	Yes	42.00	$64.90	$64.90	$0.00	$64.90	
DOXYCYCLINE HYCLATE/100 MG						ERIC WILKE					
						Totals:	$64.90	$64.90	$0.00	$64.90	

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TAMUS
OFFICE OF RISK MANAGEMENT

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION STATEMENT OF PHARMACY SERVICES

Send this form to the injured employee's workers' compensation insurance carrier.

Coverage Verification

☒ In accordance with Rule 134.501, I affirm that I have verified the workers' compensation insurance coverage for this employer, confirmed that a work-related injury of the employee named below has been reported to the employer for the listed date of injury, and have kept documentation regarding the means of verification/confirmation on file. (See DCW FORM-66 Instructions for the Verification Statement.)

Section 1

1. Pharmacy's Name, Address, and Phone #:
KROGER PHARMACY
3535 LONGMIRE DR
COLLEGE STATION, TX 77845-5271
Phone (979) 485-8813
Fax

2. Date of Billing:
11/24/10

3. Pharmacy's NCPDP #: (NPI #)
4515120 1962575480

4. Remit Payment To (if different from above):
StoneRiver - Pharmacy Solutions
P.O. BOX 100994
ATLANTA, GA 30384-0994

5. Invoice #:
34058118

6. Payee's FEIN
62-1770924

7. Carrier's Name and Address:
TEXAS A & M UNIVERSITY SYSTEM
ATTN: kay ball
200 TECHNOLOGY WAY STE 1120
COLLEGE STATION, TX 77845-3424

8. Employer's Name, Address, and Phone #:
TEXAS A&M
332 WERC
COLLEGE STATION, TX 77843
(979) 845-3211

9. Injured Employee's Name, Address, and Phone #:

15. Prescribing Doctor's Name, Address, and Phone #:
WILKE ERIC MD
300 KRENEK TAP RD
COLLEGE STATION, TX 77840-5022
(979) 764-5100

10a. Injured Employee's ID #

10b. ID Jurisdiction
U.S.

10c. ☒ SSN ☐ DL# ☐ Passport ☐ Visa ☐ Green Card

16. Prescribing Doctor's DEA#: (NPI #)
FW0401163 1578591194

11. DOI:
11/15/10

12. DOB

13. Claim # (if known):

14. Carrier's Claim # (if known):
211013423

RECEIVED
2010 DEC -6 AM 11:30
TAMUS OFFICE OF RISK MANAGEMENT

Section 2

17. ☒ Generic Dispensed ☐ Name Brand Dispensed
18. Generic Available? ☐ YES ☐ NO
19. ☐ Dispensed as Written ☐ Dispensed per Injured Employee request
20. Date filled: 11/15/10
21. Generic NDC: 53489011905
22. Name Brand NDC:
23. Quantity: 42
24. Days Supply: 21
25. Refills Remaining: 0
26. Paid by Employee:
27. Drug Name and Strength: DOXYCYCL HYC CAP 100MG
28. Rx #: 6877962
29. Amount Billed: 64.90

17. ☐ Generic Dispensed ☐ Name Brand Dispensed
18. Generic Available? ☐ YES ☐ NO
19. ☐ Dispensed as Written ☐ Dispensed per Injured Employee request
20 Date filled
21 Generic NDC:
22. Name Brand NDC:
23 Quantity:
24 Days Supply:
25 Refills Remaining
26 Paid by Employee
27 Drug Name and Strength
28 Rx #
29 Amount Billed

17. ☐ Generic Dispensed ☐ Name Brand Dispensed
18 Generic Available? ☐ YES ☐ NO
19 ☐ Dispensed as Written ☐ Dispensed per Injured Employee request
20. Date filled:
21 Generic NDC:
22 Name Brand NDC:
23 Quantity
24 Days Supply
25 Refills Remaining
26 Paid by Employee
27 Drug Name and Strength
28 Rx #
29 Amount Billed

INVOICE # 34058118 TOTAL 64.90
12/16/10 DN

CHECK LIST FOR NEW FOLDERS .

- ☐ Prepare lost time chart
- ☑ Acceptance Letter
- ☑ Contact injured employee for statement by telephone (date 08/07/09)
- ☑ Employer initial status of claim (date 08/07/09)
  - ☐ Wage statement
  - ☐ Request for Paid Leave
  - ☐ Supplemental
  - ☐ Request emailed on _____
- ☑ Initial questionnaire to Claimant
- ☐ Work status tracking log
- ☐ Copy of work status to employer
- ☐ Update work status in Allegro
- ☑ Update claim notes for extent of injury & controverted
- ☐ PLN ☐1 _____ ☐2 _____ ☐6 _____ ☐11 _____
- ☐ EDI 1st report Did Salary Continue? Y or N _____
- ☐ DWC Record Check
- ☐ Request witness statement
- ☐ COMP Divider
- ☑ Diary
  - ☑ PLN 11 (define extent of injury within first 60 days)
  - ☐ 8th day, elimination week, 26 weeks, & FMLA ends

Subrogated claim:

- ☐ Notice to claimant
- ☐ Notice to 3rd party
- ☐ Notice to 3rd party insurance
- ☐ Request accident report

Work status change:

- ☐ Update lost time in Allegro
- ☐ Update work status tracking log
- ☐ Copy of work status to Employer

Impairment benefits:

- ☐ PLN 3
- ☐ Update Allegro MMI/IR
- ☐ Subsequent Status Claim Form to Employer
- ☐ Request Wage Statement

Revised 7/05

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2366
RECIPIENT ADDRESS	917134624143
DESTINATION ID	
ST. TIME	09/24 18:24
TIME USE	00'26
PAGES SENT	1
RESULT	OK

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Toll Free: 866-249-8574 • Fax 979-458-6247 • http://tamusystem.tamu.edu

NOTICE OF DISPUTED ISSUE(s) AND REFUSAL TO PAY BENEFITS

FAXED TO STARR
DATE: 9/24/09

DATE: September 23, 2009

TO: NAME OF INJURED EMPLOYEE:
ADDRESS:
CITY, STATE, ZIP:

RE: DATE OF INJURY: 07/28/2009
NATURE OF INJURY: Needle Stick
PART OF BODY INJURED: Right Thumb
EMPLOYEE SSN:
DWC #: Unassigned
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 209-0621-23
EMPLOYER NAME: Texas A&M Health Science Center
EMPLOYER ADDRESS: 301 Tarrow Street, 6th Floor
EMPLOYER CITY, STATE, ZIP: College Station, TX 77840

We are disputing entitlement of any body part, medical condition, or diagnosis other than a needle stick of the right thumb, only because:

The Texas A&M University System as the workers' compensation insurance carrier for Texas A&M Health Science Center accepts that the compensable injury extends to and includes a needle stick of the right thumb, only, that occurred on or about 07/28/2009. Carrier disputes that the compensable injury extends to and includes any and all other body parts and/or medical conditions. If further evidence is presented our decision will be reviewed.

If you do not agree with the dispute and refusal to pay benefits, please contact me:

Adjuster's Name: Kaye Ball
Toll Free Telephone #: 1-866-249-8574
Fax #/E-mail Address: 1-979-458-6247/KBall@tamu.edu

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. Contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in

The Texas A&M University System

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NOTICE OF DISPUTED ISSUE(s) AND REFUSAL TO PAY BENEFITS

DATE: September 23, 2009

TO: NAME OF INJURED EMPLOYEE:
ADDRESS:
CITY, STATE, ZIP: College Station, TX 77845

FAXED TO STARR
DATE: 9/24/09

RE: DATE OF INJURY: 07/28/2009
NATURE OF INJURY: Needle Stick
PART OF BODY INJURED: Right Thumb
EMPLOYEE SSN:
DWC #: Unassigned
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 209-0621-23
EMPLOYER NAME: Texas A&M Health Science Center
EMPLOYER ADDRESS: 301 Tarrow Street, 6th Floor
EMPLOYER CITY, STATE, ZIP: College Station, TX 77840

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Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

Cc: DWC, 7551 Metro Center Drive, Ste. 100, Austin, Texas 78744-1645

23

INITIAL RESERVES
MEDICAL
INDEMNITY
LAE

LOST TIME Y (N) ADJUSTER KB

ation,

CLAIM #

CARRIER'S CLAIM # 209-0621-23

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)	2. Sex F ☐ M ☑
3. Social Security Number	4. Home Phone / 5. Date of Birth (m-d-y)
6. Does the Employee Speak English? If No, Specify Language: YES ☑ NO ☐	
7. Race: White ☑ Black ☐ Asian ☐	8. Ethnicity: Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address Street or P.O. Box	
City / State / Zip Code / County: Brazos	
10. Marital Status	
11. Number of Dependent Children: 2	12. Spouse's Name
14. Doctor's Mailing Address (Street or P.O.Box): 1602 Rock Prairie Rd.	
City: College Station / State: TX / Zip Code: 77845	

15. Date of Injury (m-d-y): 07-28-2009	16. Time of Injury: 11:45 am ☑ pm ☐	17. Date Lost Time Began (m-d-y): NLT
18. Nature of Injury: needle stick	19. Part of Body Injured or Exposed: right thumb	
20. How and Why Injury/Illness Occurred: While infecting mice with Borrelia burgdorferi in a Biosafety cabinet in full compliance, needle slipped.		
21. Was employee doing his regular job? YES ☑ NO ☐	22. Worksite Location of Injury (stairs, dock, etc.): Laboratory - CMP,	
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site: Comparative Medicine		
Street or P.O. Box: TAMU / County: Brazos		
City: College Station / State: TX / Zip Code: 77843		
24. Cause of Injury(fall, tool, machine, etc.): Needle		
25. List Witnesses: Dana Shaw		
26. Return to work date/or expected (m-d-y): NLT	27. Did employee die? YES ☐ NO ☑	28. Supervisor's Name: Dr. John Quarles
29. Date Reported (m-d-y): 07-28-2009		

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2009 AUG -6 AM 10:28
TAMUS RISK MANAGEMENT OFFICE

30. Date of Hire (m-d-y): 07-15-1996	31. Was employee hired or recruited in Texas? YES ☑ NO ☐	32. Length of Service in Current Position: Months ____ Years 13	33. Length of Service in Occupation: Months ____ Years 13
34. Employee Payroll Classification Code: 7100	35. Occupation of Injured Worker: Professor		
36. Rate of Pay at this Job: $ ____ Hourly $ monthly Weekly	37. Full Work Week is: 40 Hours 5 Days	38. Last Paycheck was: $ ____ for ____ Hours or 30 Days	39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form: Norma Jones, Business Administrator	41. Name of Business
42. Business Mailing Address and Telephone Number: Street or P.O. Box: College of Medicine, TAMU / Telephone: (979) 845-1314	43. Business Location (if different from mailing address) Number and Street: 407 Reynolds Medical Bldg.
City: College Station / State: TX / Zip Code: 77843	City: College Station / State: TX / Zip Code: 77843
44. Federal Tax Identification Number: 74-2907553	45. Primary North American Industry Classification System Code: (6 digit) None
46. Specific NAICS Code (6 digit): None	47. Texas Comptroller Taxpayer No.: None
48. Workers' Compensation Insurance Company: None	49. Policy Number: None-self insured

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X Norma Jones Date 07/28/2009

DWC FORM-1 (Rev. 10/05) Page 3

Entered 8/6/09

DIVISION OF WORKERS' COMPENSATION

[redacted]

209-0621-23KB

TEXAS Department of State Health Services

INFECTIOUS DISEASE CONTROL
CONTAMINATED SHARPS INJURY REPORTING FORM

The facility where the injury occurred should complete the form and submit it to the local health authority where the facility is located. If no local health authority is appointed for this jurisdiction, submit to the regional director of the Texas Department of State Health Services (DSHS) regional office in which the facility is located. Address information for regional directors can be obtained on the DSHS webpage at http://www.dshs.state.tx.us/regions/default.shtm. The local health authority, acting as an agent for the Texas Department of State Health Services will receive and review the report for completeness, and submit the report to: IDEAS, Texas DSHS, 1100 West 49th Street, T-801, Austin, Texas 78756-3199. Obtain copies at http://www.dshs.state.tx.us/idcu/health/infection_control/bloodborne_pathogens/reporting or from Texas Department of State Health Services regional offices.

Please complete a form for each exposure incident involving a sharp.

NOTE: If the injury occurred BEFORE the sharp was used for its original intended purpose, *do not* submit this form

Facility (agency/institution) where injury occurred: Texas A&M University - Comparative Medicine Program
Street address (no post office box):Room LARR Bldg.
City:College Station **County:Brazos** **Zip code:77843**
Street address of reporter if different from facility where injury occurred:407 Reynolds Medical Bldg.

Date:7/28/2009
Reporter's Name:Norma Jones
Reporter's Telephone:979-845-1314
Reporter's e-mail:jones@medicine.tamhsc.edu

1. Date of injury:7.28.9 **Time of injury:**11:45 ☒am ☐ pm **Age of injured:44** **Sex of injured:** ☒ M ☐ F
2. Type and Brand of sharp involved (*Check one box*) **List brand name of sharp:**B-D 1ml 26G 3/8

Needles

- ☐ Arterial catheter introducer needle
- ☐ Blood gas syringe
- ☐ Central line catheter needle (cardiac, etc.)

Disposable Syringe

- ☐ Insulin
- ☐ 20-gauge needle
- ☐ 21-gauge needle
- ☐ 22-gauge needle
- ☐ 23-gauge needle
- ☐ 24/25-gauge needle
- ☒ Tuberculin

- ☐ Drum catheter needle
- ☐ IV catheter stylet
- ☐ Needle on IV line (includes piggybacks & IV line connectors
- ☐ Needle, not sure what kind
- ☐ Pre-filled cartridge syringe
- ☐ Spinal or epidural needle
- ☐ Suture needle
- ☐ Syringe, other type
- ☐ Unattached hypodermic needle
- ☐ Vacuum tube blood collection holder/needle
- ☐ Winged steel needle (includes butterfly, winged-set type devices)

Other

- ☐ Other vascular catheter needle (cardiac, etc.)
- ☐ Other non-vascular catheter needle (ophthalmology, etc.)
- ☐ Other nonsuture

Surgical Instruments *(or other sharp items)*

- ☐ Bone chip/chipped tooth
- ☐ Bone cutter
- ☐ Drill bit/bur
- ☐ Electro-cautery device
- ☐ Fingernails/teeth
- ☐ Huber needle
- ☐ Lancet (finger or heel stick)
- ☐ Microtome blade
- ☐ Pickups/forceps/ hemostats/clamps
- ☐ Pin (fixation, guide pin)
- ☐ Pipette (plastic)
- ☐ Razor
- ☐ Retractors, skin/bone hooks
- ☐ Scalpel, disposable
- ☐ Scalpel, reusable

Scissors

Sharp item, not sure what kind

- ☐ Specimen/test tube (plastic)
- ☐ Staples/steel sutures
- ☐ Towel clip
- ☐ Trocar
- ☐ Vacuum tube (plastic)
- ☐ Wire (suture/fixation/guide wire)
- ☐ Other sharp

Glass

- ☐ Capillary tube
- ☐ Glass slide
- ☐ Glass item, not sure what kind
- ☐ Medication ampule/vial/IV bottle
- ☐ Pipette
- ☐ Specimen/test tube
- ☐ Vacuum tube
- ☐ Other glass item:

[redacted]

209-0621-23 KB

3. Original intended use of sharp (*check one box*)

- ☐ Connect IV line (intermittent IV/piggyback/IV infusion/other IV line connection
- ☐ Contain a specimen or pharmaceutical (glass item)
- ☐ Cutting
- ☐ Dental ☐ Extraction ☐ Hygiene ☐ Orthodontic ☐ Periodontal ☐ Restorative ☐ Root Canal
- ☐ Dialysis
- ☐ Draw arterial blood sample...*If used to draw blood was it* ☐ direct stick *or* ☐ drawn from a line
- ☐ Draw venous blood sample
- ☐ Drilling
- ☐ Electrocautery
- ☐ Finger Stick/heel stick
- ☐ Heparin or saline flush
- ☒ Injection, intra-muscular/subcutaneous/intra-dermal, or other injection through the skin (syringe)
- ☐ Obtain a body fluid or tissue sample (urine/CSF//amniotic fluid/other fluid, biopsy)
- ☐ Other injection into (or aspiration from) IV injection site or IV port (syringe)
- ☐ Remove central line/porta catheter
- ☐ Start IV or set up heparin lock (IV catheter or winged set-type needle)
- ☐ Suturing ☐ deep ☐ skin
- ☐ Tattoo
- ☐ Unknown/not applicable
- ☐ Wiring
- ☐ Other

4. When and How Injury Occurred...

☐ Before (DO NOT report to DSHS) ☒ during ☐ after the sharp was used for its intended purpose

If the exposure occurred during or after the sharp was used, was it (*check one box*)

- ☐ Activating safety device
- ☐ Between steps of a multistep procedure (carrying, handling, passing/receiving syringe/instrument, etc.)
- ☐ Device malfunctioned
- ☐ Device pierced the side of the disposal container
- ☐ Disassembling device or equipment
- ☐ Found in an inappropriate place (eg. Table, bed, linen, floor, trash)
- ☐ Interaction with another person
- ☒ Laboratory procedure/process
- ☐ Patient moved during the procedure
- ☐ Preparation for reuse of instrument (cleaning, sorting, disinfecting, sterilizing, etc.)
- ☐ Recapping
- ☐ Suturing
- ☐ Use of sharps container
- ☐ Unsafe practice
- ☐ Use of IV/central line
- ☐ Other

5. Did the device being used have engineered sharps injury protection? ☐ yes ☒ no ☐ do not know

A. Was the protective mechanism activated? ☐ yes ☒ no ☐ do not know

B. Did the exposure incident occur ☐ before ☐ during ☐ after activation of the protective mechanism

6. Was the injured person wearing gloves? ☒ yes ☐ no ☐ do not know

7. Had the injured person completed a hepatitis B vaccination series? ☐ yes ☐ no ☒ do not know

8. Was there a sharps container readily available for disposal of the sharp? ☒ yes ☐ no

Did the sharps container provide a clear view of the level of contaminated sharps? ☒ yes ☐ no

9. Had the injured person received training on the exposure control plan in the 12 months prior to the incident? ☒ yes ☐ no

10. Involved body part (*check one box*) ☒ hand ☐ arm ☐ leg/foot ☐ face/head/neck ☐ torso (front or back)

[redacted]

209-0621-23 KB

11. Job Classification of injured person (*check only one box*)

- ☐ Aide (e.g. CAN, HHA, orderly)
- ☐ Attending physician (MD, DO)
- ☐ Central supply
- ☐ Chiropractor
- ☐ Clerical/administrative
- ☐ Clinical lab technician
- ☐ Counselor/social worker
- ☐ CRNA/NP
- ☐ Dentist
- ☐ Dental assistant/technician
- ☐ Dental hygienist
- ☐ Dental student
- ☐ Dietician
- ☐ EMT/ paramedic
- ☐ Fellow
- ☐ Firefighter
- ☐ Food service
- ☐ Hemodialysis technician
- ☐ Housekeeper/laundry
- ☐ Intern/resident
- ☐ Law enforcement officer
- ☐ Licensed vocational nurse
- ☐ Maintenance staff
- ☐ OR/surgical technician
- ☐ Pharmacist
- ☐ Phlebotomist/venipuncture/IV team
- ☐ Physician assistant
- ☐ Physical therapist
- ☐ Psychiatric technician
- ☐ Public health worker
- ☐ Radiologic technician
- ☐ Registered nurse
- ☒ Researcher
- ☐ Respiratory therapist/technician
- ☐ Safety/security
- ☐ School personnel (not nurse)
- ☐ Transport/messenger
- ☐ Volunteer
- ☐ Other

12. Employment Status of Injured Person (*check one box*)

☒ Employee ☐ Student ☐ Contractor/contract employee ☐ Volunteer ☐ Other

If not directly employed by reporter, name the employer/service/agency/school:

13. Location/Facility/Agency in which sharps injury occurred (*check one box*)

- ☐ Blood bank/center/mobile
- ☐ Clinic
- ☐ Correctional facility
- ☐ Dental facility
- ☐ EMS/Fire/Police
- ☐ Home health
- ☐ Hospital
- ☒ Laboratory (freestanding)
- ☐ Medical examiner office/morgue
- ☐ Outpatient treatment (e.g. dialysis, infusion therapy)
- ☐ Residential facility (e.g. MHMR, shelter)
- ☐ School/college
- ☐ Other

14. Work Area where Sharps Injury Occurred (*check one box*)

- ☐ Ambulance
- ☐ Autopsy/pathology
- ☐ Blood bank center/mobile
- ☐ Central supply
- ☐ Critical care unit
- ☐ Dental clinic
- ☐ Dialysis room/center
- ☐ Emergency department
- ☐ Endoscopy/bronchoscopy/ cystoscopy
- ☐ Field (non EMS)
- ☐ Floor (not patient room)
- ☐ Home
- ☐ Infirmary
- ☐ Jail unit
- ☒ Laboratory
- ☐ L & D/Gynecology unit
- ☐ Medical/Outpatient clinic
- ☐ Medical/surgical unit
- ☐ Nursery
- ☐ Patient/resident room
- ☐ Pediatrics
- ☐ Pre-op or PACU
- ☐ Procedure room
- ☐ Rescue setting (non ER)
- ☐ Radiology department
- ☐ Seclusion room/psychiatric unit
- ☐ Service/Utility area (e.g. laundry)
- ☐ Surgery/operating room
- ☐ Other

COMMENTS

[redacted]

INITIAL CLAIM QUESTIONNAIRE

Claimant:
Address:

Claim # 209-0621-23 RB
Date of Injury: 07/28/2009
Date mailed: 08/10/2009

Please complete, sign, and date this claims questionnaire and return in the enclosed postage paid envelope as soon as possible.

1. Did your injury occur while performing your normal job duties?

Yes

2. Please state in your own words where and how your injury occurred.

I was at the LARR (CMP) facility at Texas A&M Univ. infecting mice with Borrelia burgdorferi when the syringe slipped and the needle grazed my glove and stuck my thumb. There was no obvious hole (or blood) but I erred on the side of caution and went to Scott and White Clinic for treatment.

3. Please state in your own words any physical harm or damage to your body that resulted from the work related incident.

None

RECEIVED
2009 AUG 17 AM 10:
TAMUS
OFFICE OF RISK MANAGEMENT

4. Have you sought medical attention for this injury? If so please indicate your choice of primary care physician. Have you seen this physician in the past three years for other conditions whether work related or not.

Yes; went to the Scott & White Urgent Care Clinic as directed by Occupational Health & Safety at Texas A&M University.

5. If you have multiple employers please list the name and address of each employer

N/A

Injured employee signature

8/13/09
Date

c:inques

The Texas A&M University System

Office of the Treasurer
Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Fax 979-458-6247 • http://tamusystem.tamu.edu

August 06, 2009

Dear ,

This office is in receipt of a First Report of injury indicating that you sustained a work-related injury on 07/28/2009.

Any medical bills you incur as a direct result of this injury should be immediately forwarded to this office for consideration. Prescription drugs may be filled at any pharmacy. Please do not use your health care insurance to have these prescriptions filled.

If you miss more than a day of work as result of this injury you must contact your department to ensure that you receive all the benefits to which you may be entitled.

If you have any questions regarding your claim, please come by our office or call us at (979) 458-6330.

Sincerely,

KAYE BALL
Workers' Compensation Insurance
Risk Management Division

Enclosure

MEDICAL SERVICES CHART

CLAIM# 209-0621-23

CLAIMANT

DOI: 7/28/09 Nature of Injury Needle Stick

Body Part Injured Rt. Thumb

Treating Dr

Approved Change

Consulting/Referral (approval date)

RME Date

Result

D/D Date

Result

Accepted diagnosis

Needle Stick - Rt. Thumb (Herpes Disease)

Initial Treatment Plan

Secondary Treatment Plan or Changes

X-Ray
Body Part Date Result

MRI
Body Part Date Result

C/T Scan
Body Part Date Result

Bone Scan
Body Part Date Result

Myelogram
Body Part Date Result

EMG
Body Part Date Result

PHYSICAL THERAPY

WEEK 1	WEEK 1
WEEK 2	WEEK 2
WEEK 3	WEEK 3
WEEK 4	WEEK 4
WEEK 5	WEEK 5
WEEK 6	WEEK 6
WEEK 7	WEEK 7
WEEK 8	WEEK 8

COMMENTS:

SURGICAL PROCEDURES

Date
Date
Date
Date
Date

DENIED MEDICATIONS

PREAUTHORIZATIONS

DATE	YES/NO	PROCEDURE

BODY PART DENIED
DATE PLN 1 FILED Y/N
BODY PART DENIED
DATE PLN 1 FILED Y/N
BODY PART DENIED
DATE PLN 1 FILED Y/N
NOTES:

209-0621-29KB

SCOTT & WHITE

Name:
MRN: 9126385
DOB:

Printed 08/04/2009 10:21 by Candace Slightom
TITLE: 07/28/2009 BCS Urgent Care Thomas Kenneth Welch 9126385

SCOTT AND WHITE MRN: 9126385
Bryan-College Station Clinic Note

DOB:
DATE OF SERVICE: 07/28/2009

Today Care

WORKER'S COMPENSATION

EMPLOYER:
Texas A and M University.

DATE OF INJURY:
July 28, 2009.

PRIMARY CARE PHYSICIAN:
James V. Bonds, MD

HISTORY OF PRESENT ILLNESS:
The patient is a 44-year-old male who does work in a microbiology area. He is involved with research dealing with Lyme disease. He had Lyme infectious agent in a needle that he was to inject a mouse today. Somehow, the syringe he feels punctured the glove on his hand. It did have material in it and it had not been injected yet into the animal. He states that he did not notice any blood within the glove nor any blood on the thumb despite trying to manipulate that area. It is a little sore but had no true blood component present. He has no significant underlying medical problems.

ALLERGIES:
Tetanus.

SOCIAL HISTORY:
Negative for tobacco use.

PHYSICAL EXAMINATION:

209-0621-23
KB

VITAL SIGNS: Temp 98.9, pulse 64 respirations 16, blood pressure 123/71. Weight 168 pounds.
SKIN: Right thumb shows no evidence of puncture site or bleeding at present time. No erythema or redness noted.

ASSESSMENT PLAN:
Needle sick with a potential exposure to Lyme disease. I will go ahead and empirically treat him as this were an initial tick bite with treatment with doxycycline 100 mg twice a day for a total of 3 weeks. If he would develop any fever, chills, unusual rash or general arthralgias then followup is recommended. No titer was done today as I would not anticipate any evidence of titer with initial stick at this time. He will be released back to work with no restrictions and no anticipated need for followup unless other symptoms occur.

Preliminary / Not Reviewed by

Thomas Kenneth Welch, MD
125 / 30225
979-691-3802
dd: 07/28/2009 5:28 P dt: 07/28/2009 8:59 P
Job #: 000755107 - 11855678 -
Doc ID#: 200907280992725600

cc: James V Bonds, MD

INITIAL CLAIM QUESTIONNAIRE

Claimant:
Address:

Claim # 209-0621-23
Date of Injury: 07/28/2009
Date mailed: 08/10/2009

Please complete, sign, and date this claims questionnaire and return in the enclosed postage paid envelope as soon as possible.

1. Did your injury occur while performing your normal job duties?

2. Please state in your own words where and how your injury occurred.

3. Please state in your own words any physical harm or damage to your body that resulted from the work related incident.

Rec'd
8/12/09

4. Have you sought medical attention for this injury? If so please indicate your choice of primary care physician. Have you seen this physician in the past three years for other conditions whether work related or not.

5. If you have multiple employers please list the name and address of each employer

Injured employee signature

Date

c inques

WORKERS' COMPENSATION
INITIAL STATUS OF CLAIM REPORT

To:	**Matt Walton**	Date:	**08/07/09**
	TAM-HSC	RE:	
		Employed By	**TAM-HSC**
		Supervisor:	**Dr. John Quarles**
		D.O.I.:	**07/28/2009**
		Claim No.:	**209-0621-23**

PLEASE USE THE INFORMATION BELOW AS YOU DEEM NECESSARY

☐ We have received a medical bill/report that indicates an injury may have occurred on . Please verify with your records. If an injury occurred forward a copy of the Employer's First Report of Injury or your incident/accident report so we may timely process the medical bill. If an injury has not been reported, please notify this office, in writing, as soon as possible. ***If a response is not received within 3 days of receipt of this notice the claim for compensability will be accepted.***

☐ The employer's First Report of Injury has been received. Weekly compensation benefits will begin after the seven day waiting period pursuant to the Texas Workers' Compensation Act if disability continues **unless a Supplemental Report of Injury is received indicating the employee has returned to work or unless the Request for Paid Leave is received indicating that the employee will use sick and or annual leave.** A wage statement is required if the employee is disabled for more than eight days, even if the employee is using sick/annual leave of FMLA leave.

☒ This claim has been accepted as a compensable injury.

☐ This is a questionable claim. However, sufficient evidence does not exist at this time to contest compensability. Please provide us with written witness statements, and any other objective information that would assist us in making a determination of compensability.

☐ This claim has been denied because:
- ☐ There was no injury in course and scope of employment
- ☐ The injury was not sustained in the course & scope of employment
- ☐ Untimely notice of injury was given
- ☐ The injury is considered an ordinary disease of life
- ☐ Disability only, medical documentation required to establish physical harm
- ☐ Other:

☐ Other:
Thanks.

Please direct any questions regarding this claim and the above information to:

The Texas A&M University System
Office of Risk Management & Safety
College Station, TX 77845-3424
Phone: 979/458-6330 Fax: 979/458-6247

Adjuster: Kaye Ball
F:wci,procedure;office

TAMUS DEPT VOUCHER NO 261010# 52951

STATE OF TEXAS PURCHASE VOUCHER

Agency			Agency Voucher No
TEXAS A&M UNIVERSITY SYSTEM College Station,TX 77840		Order Date 09/04/2009	Requisition No NONE
	Invoice Date 09/04/2009	Voucher Amount $89.26	Payee Reference No NONE	Control No NONE

Comptroller Vendor ID No		Agency Object	Amount
1742958277	NONE	6462	$89.26 E N C

Pay To (Name, Address, City, State, Zip)
SCOTT & WHITE
P.O. BOX 847408
DALLAS, TX 75284-7408

Account Name	TOTAL
Workers's Compensations Ins.	$89.26

ENCUMBRANCE LEDGER

Requisition No	Amount

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	Amount
07/28/2009 - 07/28/2009	209062123	$89.26

VENDOR CERTIFICATION
(Use when no invoice is available)
I certify the described articles or services were contracted for and the account is true,correct and unpaid.

SIGNATURE

AGENCY CERTIFICATION
I certify that the above services were rendered,or goods received and that they correspond in every particular with contract under which they were procured and that the invoice is true and unpaid

DATE APPROVED FOR PAYMENT

NAME (PERSON RECEIVING GOODS)	DATE	09/04/2009	NAME
NAME (DEPT HEAD)	DATE	09/04/2009	TITLE

DWC #

Carrier's Claim # 209062123

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of Injury
		07/28/2009

4. Injured employee's mailing address (Street or P.O. Box)

5. Employer's name and address
TAMUS HEALTH SCIENCE CENTER
2121 WEST HOLCOMBE BOULEVARD MS 1201, HOUSTON, TX 770303303

6. Health care provider's name and address
SCOTT & WHITE
P.O. BOX 847408, DALLAS, TX 75284-7408

7. Insurance carrier's name and address
The Texas A&M University System
200 Technology Way, Suite 1120, College Station, TX 77845

8. Health care provider's federal tax I.D. number
742958277

9. Name and address of the company performing the audit
Starr Comprehensive Solutions, Inc.
P.O. Box 801464, Houston, TX 77280-1464

Date of the audit: 09/01/2009

10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc.
Phone: 866-462-4197 Fax: 713-462-4143

Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s).

Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act.

ITN Number: 00295802

ICD9 Codes used: 919.6 - SUPERFICIAL FOREIGN BODY (SPLINTER) OF OTHER MULTIPLE AND UNSPECIFIED SITES WITH

Dates of Service From Date	Thru Date	Procedure Code and Description	Modifier	Units	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
07/28/2009	07/28/2009	99202 OFFICE/OP VISIT, NEW PT, 3 KEY COMPONENTS: EXPAND PROB FOCUS HX; EXPAND PROB FOC		1.00	$120.00	$89.26	$0.00	$89.26	W1
		Totals:			**$120.00**	**$89.26**	**$0.00**	**$89.26**	

Reason for Reduction or Denial:
W1 - Workers Compensation State Fee Schedule Adjustment

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

WORKERS COMPENSATION
TEXAS A&M UNIVERSITY
200 TECHNOLOGY #1120
COLLEGE STATION, TX 77840

WC1

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID) [X]	1a. INSURED'S I.D NUMBER (For Program in Item 1) :
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) :	3. PATIENT'S BIRTH DATE SEX M [X] F [ ]
	4. INSURED'S NAME (Last Name, First Name, Middle Initial) TAMU,
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [ ]
	7. INSURED'S ADDRESS (No., Street) ~~200 TECHNOLOGY 1120~~
CITY / STATE	8. PATIENT STATUS Single [ ] Married [ ] Other [ ]
	CITY COLLEGE STATION / STATE TX
ZIP CODE / TELEPHONE (Include Area Code) 77845 (	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
	ZIP CODE 77840 3 / TELEPHONE (Include Area Code) (979) 458-6330
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10 IS PATIENT'S CONDITION RELATED TO:
	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER 209-0601-23 KB	a. EMPLOYMENT? (Current or Previous) [X] YES [ ] NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [X] NO
	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]
	b. EMPLOYER'S NAME OR SCHOOL NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
	c. INSURANCE PLAN NAME OR PROGRAM NAME WORKERS COMPENSATION
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 07/28/09	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17a. XS / 17b. NPI 1720040637	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1,2,3 or 4 to Item 24E by Line) 1. 9196 3. 2. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07/28/09	07/28/09	11		99202		1	120 00	1		0B	MD 20356TX
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
742958277 [X]	921500684B4Q0	[X] YES [ ] NO	$ 120 00	$ 89.26	$ 120 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
WELCH, THOMAS
Signature on File MD
08/03/09
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
CE BCS URGENT CARE
1600 UNIVERSITY DR EAST
COLLEGE STATION TX 77840
a 1093779704 b TJ 742958277

33. BILLING PROVIDER INFO & PH #
SCOTT AND WHITE
PO BOX 847408
DALLAS TX 752847408
(254) 724-2911
a 1922061993 b 9/4/09 ON

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM 1500 (08/05)

WCMS-1500CS

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

Hammond SO -11-012-013
TAMUS 0083

TAMUS DEPT VOUCHER NO 261010# 53050

STATE OF TEXAS PURCHASE VOUCHER

Agency TEXAS A&M UNIVERSITY SYSTEM College Station,TX 77840			Agency Voucher No	
		Order Date 09/07/2009	Requisition No NONE	
	Invoice Date 09/07/2009	Voucher Amount $63.80	Payee Reference No NONE	Control No NONE
Comptroller Vendor ID No 1621770924 NONE			Agency Object	Amount
Pay To (Name, Address, City, State, Zip) STONERIVER - PHARMACY SOLUTIONS PO BOX 100994 ATLANTA, GA 30384			6462	$63.80 E N C
Account Name Workers's Compensations Ins.			TOTAL	$63.80

ENCUMBRANCE LEDGER	
Requisition No	Amount

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	Amount
07/28/2009 - 07/28/2009	209062123	$63.80

VENDOR CERTIFICATION
(Use when no invoice is available)
I certify the described articles or services were contracted for and the account is true,correct and unpaid.

SIGNATURE

AGENCY CERTIFICATION
I certify that the above services were rendered,or goods received and that they correspond in every particular with contract under which they were procured and that the invoice is true and unpaid

DATE APPROVED FOR PAYMENT

NAME (PERSON RECEIVING GOODS)	DATE	09/07/2009	NAME	
NAME (DEPT HEAD)	DATE	09/07/2009	TITLE	

DWC #

Carrier's Claim # 209062123

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of injury
		07/28/2009

4. Injured employee's mailing address (Street or P.O. Box)	5. Employer's name and address
	TAMUS HEALTH SCIENCE CENTER 2121 WEST HOLCOMBE BOULEVARD MS 1201, HOUSTON, TX 770303303
6. Health care provider's name and address STONERIVER - PHARMACY SOLUTIONS PO BOX 100994, ATLANTA, GA 30384	7. Insurance carrier's name and address The Texas A&M University System 200 Technology Way, Suite 1120, College Station, TX 77845
8. Health care provider's federal tax I.D. number 621770924	Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s).
9. Name and address of the company performing the audit Starr Comprehensive Solutions, Inc. P.O. Box 801464, Houston, TX 77280-1464	Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act.
Date of the audit: 09/02/2009	ITN Number: 00296073
10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc. Phone: 866-462-4197 Fax: 713-462-4143	

RECEIVED
2009 SEP -3 AM 8:03
OFFICE OF INJURED EMPLOYEE

Date / Product/Strength	Rx. #	NDC #	Day Supply	Refill #	Generic Drug	Quantity / Doctor	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
07/28/2009 DOXYCYCLINE HYCLATE/100 MG	51928	00143314205	21	0	Yes	42.00 THOMAS WELCH	$63.80	$63.80	$0.00	$63.80	
						Totals:	$63.80	$63.80	$0.00	$63.80	

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION STATEMENT OF PHARMACY SERVICES

Send this form to the injured employee's workers' compensation insurance carrier.

Coverage Verification

☒ In accordance with Rule 134.501, I affirm that I have verified the workers' compensation insurance coverage for this employer, confirmed that a work-related injury of the employee named below has been reported to the employer for the listed date of injury, and have kept documentation regarding the means of verification/confirmation on file. (See DCW FORM-66 Instructions for the Verification Statement.)

Section 1

1. Pharmacy's Name, Address, and Phone #:
SCOTT & WHITE PHARMACY
1110 EARL RUDDER FWY S
COLLEGE STATION, TX 77840-2626
Phone (979) 691-3900
Fax (979) 691-3926

2. Date of Billing: 08/09/09

3. Pharmacy's NCPDP #: 4582107 (NPI #): 1144398124

4. Remit Payment To (if different from above):
StoneRiver - Pharmacy Solutions
P.O. BOX 100994
ATLANTA, GA 30384-0994

5. Invoice #: 30193712

6. Payee's FEIN: 62-1770924

7. Carrier's Name and Address:
TEXAS A & M UNIVERSITY SYSTEM
ATTN: KAY BALL
200 TECHNOLOGY WAY STE 1120
COLLEGE STATION, TX 77845-3424

8. Employer's Name, Address, and Phone #:
TEXAS A & M UNIVERSITY
750 AGRONOMY ROAD
COLLEGE STATION, TX 77843-1475
(979) 862-4971

9. Injured Employee's Name, Address, and Phone #:
(979) 690-9250

15. Prescribing Doctor's Name, Address, and Phone #:
WELCH THOMAS KENNETH MD
1600 UNIVERSITY DR E
COLLEGE STATION, TX 77840-2199
(979) 691-3300

10a. Injured Employee's ID #:

10b. ID Jurisdiction: U.S.

10c. ☒ SSN ☐ DL# ☐ Passport ☐ Visa ☐ Green Card

16. Prescribing Doctor's DEA#: BW3188023 (NPI #): 1720040637

11. DOI: 07/28/09

12. DOB:

13. Claim # (if known):

14. Carrier's Claim # (if known): 209062123

RECEIVED
2009 AUG 11 AM 11:
TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION

Section 2

17.	18.	19.	20.	21.	22.	23.	24.	25.	26.	27.	28.	29.
☒ Generic Dispensed ☐ Name Brand Dispensed	Generic Available? ☐ YES ☐ NO	☐ Dispensed as Written ☐ Dispensed per Injured Employee request	Date filled:	Generic NDC:	Name Brand NDC:	Quantity:	Days Supply:	Refills Remaining:	Paid by Employee:	Drug Name and Strength:	Rx #:	Amount Billed:
			07/28/09	00143314205		42.000	21	0		DOXYCYCL HYC CAP 100MG	5192870	63.80
☐ Generic Dispensed ☐ Name Brand Dispensed	Generic Available? ☐ YES ☐ NO	☐ Dispensed as Written ☐ Dispensed per Injured Employee request										
☐ Generic Dispensed ☐ Name Brand Dispensed	Generic Available? ☐ YES ☐ NO	☐ Dispensed as Written ☐ Dispensed per Injured Employee request										

9/7/09 DN

INVOICE # 30193712 TOTAL 63.80

CHECK LIST FOR NEW FOLDERS

- [ ] Prepare lost time chart
- [x] Acceptance Letter
- [ ] Contact injured employee for statement by telephone (date _____)
- [x] Employer initial status of claim (date 06/30/09)
  - [ ] Wage statement
  - [ ] Request for Paid Leave
  - [ ] Supplemental
  - [ ] Request emailed on _____
- [x] Initial questionnaire to Claimant
- [ ] Work status tracking log
- [ ] Copy of work status to employer
- [ ] Update work status in Allegro
- [x] Update claim notes for extent of injury & controverted
- [ ] PLN ☐1 _____ ☐2 _____ ☐6 _____ ☐11 _____
- [ ] EDI 1st report Did Salary Continue? Y or N _____
- [ ] DWC Record Check
- [ ] Request witness statement
- [ ] COMP Divider
- [x] Diary
  - [x] PLN 11 (define extent of injury within first 60 days)
  - [ ] 8th day, elimination week, 26 weeks, & FMLA ends

Subrogated claim:

- [ ] Notice to claimant
- [ ] Notice to 3rd party
- [ ] Notice to 3rd party insurance
- [ ] Request accident report

Work status change:

- [ ] Update lost time in Allegro
- [ ] Update work status tracking log
- [ ] Copy of work status to Employer

Impairment benefits:

- [ ] PLN 3
- [ ] Update Allegro MMI/IR
- [ ] Subsequent Status Claim Form to Employer
- [ ] Request Wage Statement

Revised 7/05

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Toll Free: 866-249-8574 • Fax 979-458-6247 • http://tamusystem.tamu.edu

NOTICE OF DISPUTED ISSUE(s) AND REFUSAL TO PAY BENEFITS

DATE: August 14, 2009

TO: NAME OF INJURED EMPLOYEE:
ADDRESS:
CITY, STATE, ZIP:

FAXED TO STARR
DATE: 8/14/09

RE: DATE OF INJURY: 06/05/2009
NATURE OF INJURY: Exposure to Brucella
PART OF BODY INJURED: Body
EMPLOYEE SSN:
DWC #: Unknown
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 209-0538-06
EMPLOYER NAME: Texas AgriLife Research
EMPLOYER ADDRESS: 3000 Briarcrest Drive, Ste 504
EMPLOYER CITY, STATE, ZIP: Bryan, TX 77802

We are disputing entitlement of any body part, medical condition, or diagnosis other than an exposure to brucella, only because:

The Texas A&M University System as the workers' compensation insurance carrier for Texas AgriLife Research accepts that the compensable injury extends to and includes an exposure to brucella, only, that occurred on or about 06/05/2009. Carrier disputes that the compensable injury extends to and includes any and all other body parts and/or medical conditions. If further evidence is presented our decision will be reviewed.

If you do not agree with the dispute and refusal to pay benefits, please contact me:

Adjuster's Name: Kaye Ball
Toll Free Telephone #: 1-866-249-8574
Fax #/E-mail Address: 1-979-458-6247/KBall@tamu.edu

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. Contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

Cc: DWC, 7551 Metro Center Drive, Ste. 100, Austin, Texas 78744-1645

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2137
RECIPIENT ADDRESS	917134624143
DESTINATION ID	
ST. TIME	08/14 17:19
TIME USE	00'23
PAGES SENT	1
RESULT	OK

The Texas A&M University System

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If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

INITIAL RESERVES
MEDICAL
INDEMNITY
LAE

LOST TIME Y/N ADJUSTER KB

INITIAL RESERVES

CLAIM #

CARRIER'S CLAIM # 209-0538-06

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

RECEIVED
2009 JUN 26 AM 11:29
TAMU RISK MANAGEMENT OFFICE

1. Name (Last, First, M.I.)
2. Sex F ☑ M ☐
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y)
6. Does the Employee Speak English? If No, Specify Language
YES ☑ NO ☐
7. Race White ☑ Black ☐ Asian ☐
8. Ethnicity Hispanic ☐ Native American ☐ Other ☑
9. Mailing Address Street or P.O. Box
City State Zip Code County
10. Marital Status
11. Number of Dependent Children
12. Spouse's Name
Doctor's Name
Doctor's Mailing Address (Street or P.O.Box)
1600 University DR. E.
City State Zip Code
College Station TX 77840

15. Date of Injury (m-d-y) 06-05-2009
16. Time of Injury 10:00am ☑ pm ☐
17. Date Lost Time Began (m-d-y) N/T
18. Nature of Injury* Exposure to Brucella
19. Part of Body Injured or Exposed* whole
20. How and Why Injury/Illness Occurred*
Exposed to biohazad trash potentially contaminted with Brucella during routine cleaning of BSL-3.
21. Was employee doing his regular job? YES ☑ NO ☐
22. Worksite Location of Injury (Bldg., dock, etc.)* BSL-3 hallway
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site
TAMU Building 1197
Street or P.O. Box
VRB Hwy 60
County
Brazos
City
College Station
State
TX
Zip Code
77843
24. Cause of Injury(fall, tool, machine, etc.)*
Exposed to garbage
25. List Witnesses
Roberta Pugh
26. Return to work date/or expected (m-d-y) N/K
27. Did employee die? YES ☐ NO ☑
28. Supervisor's Name Thomas Ficht
29. Date Reported (m-d-y) 06-05-09

30. Date of Hire (m-d-y) 8-1-2002
31. Was employee hired or recruited in Texas? YES ☑ NO ☐
32. Length of Service in Current Position Months ____ Years 7
33. Length of Service in Occupation Months ____ Years 7
34. Employee Payroll Classification Code 7351
35. Occupation of Injured Worker Asst. Res. Scientist
36. Rate of Pay at this Job $ 4675.00/mo Hourly $ ____ Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 4675 for ____ Hours or 21 Days
39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form
Betty Sueltz
41. Name of Business
Vet Pathobiology
42. Business Mailing Address and Telephone Number
Street or P.O. Box Rm. 119, VMS
Telephone (979) 845-5944
City College Station State TX Zip Code 77843-4467
43. Business Location (if different from mailing address)
Number and Street
City State Zip Code
44. Federal Tax Identification Number
45. Primary North American Industry Classification System Code: (6 digit)
46. Specific NAICS Code (6 digit)
47. Texas Comptroller Taxpayer No.
48. Workers' Compensation Insurance Company
49. Policy Number
50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X Betty Sueltz Date 6-10-09

DIVISION OF WORKERS' COMPENSATION

Entered 6/26/09 dr

Coffer, Lisa

209-0538-06

From:
Sent: Friday, June 26, 2009 8:50 AM
To: Ball, Kaye
Cc: Nolan, Deborah K.
Subject: New injury?

Kaye,

We got a bill yesterday. TAMUS rec'd date = 6/23/09. On The claim # on the bill is 204023306 (DOI 12/15/03). However, the documentation indicates that this is a more recent exposure to Brucella. Would you please investigate to see if a new injury was filed this month?

DOI and DOS on the bill is 6/5/09 and provider is Scott and White.

Thanks!

Dani

TAMUS RECORDS VERIFICATION

Date: 10/31/19

INJURED EMPLOYEE _____

SOCIAL SECURITY# _____

CLAIM NUMBER	DATE OF INJURY	BODY PART	O	C	DISPOSITION
204-0233-09	12/15/03	Upper Ext; Hand(s)		✓	M$ 112.74 I$ 0 LAE$ 4.52
					M$ I$ LAE$
					M$ I$ LAE$
					M$ I$ LAE$
					M$ I$ LAE$
					M$ I$ LAE$
					M$ I$ LAE$
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					M$ I$ LAE$
					M$ I$ LAE$

INITIAL CLAIM QUESTIONNAIRE

Claimant:		Claim #	209-0538-06
Address:		Date of Injury:	06/05/2009
		Date mailed:	06/30/2009

Please complete, sign, and date this claims questionnaire and return in the enclosed postage paid envelope as soon as possible.

1. Did your injury occur while performing your normal job duties?

2. Please state in your own words where and how your injury occurred.

3. Please state in your own words any physical harm or damage to your body that resulted from the work related incident.

4. Have you sought medical attention for this injury? If so please indicate your choice of primary care physician. Have you seen this physician in the past three years for other conditions whether work related or not.

5. If you have multiple employers please list the name and address of each employer

Injured employee signature _____ Date _____ c inques

The Texas A&M University System
Office of the Treasurer
Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Fax 979-458-6247 • http://tamusystem.tamu.edu

June 26, 2009

Dear

This office is in receipt of a First Report of Injury indicating that you sustained a work-related injury on 6/5/2009.

Any medical bills you incur as a direct result of this injury should be immediately forwarded to this office for consideration. Prescription drugs may be filled at any pharmacy. Please do not use your health care insurance to have these prescriptions filled.

If you miss more than a day of work as result of this injury you must contact your department to ensure that you receive all the benefits to which you may be entitled.

If you have any questions regarding your claim, please come by our office or call us at (979) 458-6330.

Sincerely,

KAYE BALL
Workers' Compensation Insurance
Risk Management Division

Enclosure

MEDICAL SERVICES CHART

CLAIM# 209-05328-06

Treating Dr _____

Approved Change _____

onsulting/Referral (approval date)

_____

_____

DOI: 6/5/09 Nature of Injury Potential Exposure to Brucella

Body Part Injured Body / Body Systems

MMI DATE _____ %IMPAIRMENT _____

RME _____ Date _____

Result _____

D/D _____ Date _____

Result _____

Initial Treatment Plan **Initial Diagnosis Code** _____

Secondary Treatment Plan or Changes

X-Ray
Body Part _____ Date _____ Result _____

MRI
Body Part _____ Date _____ Result _____

C/T Scan
Body Part _____ Date _____ Result _____

Bone Scan
Body Part _____ Date _____ Result _____

Myelogram
Body Part _____ Date _____ Result _____

EMG
Body Part _____ Date _____ Result _____

PHYSICAL THERAPY

WEEK 1 _____	WEEK 1 _____
WEEK 2 _____	WEEK 2 _____
WEEK 3 _____	WEEK 3 _____
WEEK 4 _____	WEEK 4 _____
WEEK 5 _____	WEEK 5 _____
WEEK 6 _____	WEEK 6 _____
WEEK 7 _____	WEEK 7 _____
WEEK 8 _____	WEEK 8 _____

COMMENTS: _____

SURGICAL PROCEDURES

_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

DENIED PHARMACY

PREAUTHORIZATIONS

DATE	YES/NO	PROCEDURE

BODY PART DENIED _____
DATE _____ TWCC 21 FILED Y/N
BODY PART DENIED _____
DATE _____ TWCC 21 FILED Y/N
BODY PART DENIED _____
DATE _____ TWCC 21 FILED Y/N
NOTES: _____

209-0538-06 KB

SCOTT & WHITE

Name:
MRN: 4152394
DOB:

Printed 06/17/2009 09:13 by Candace Slightom
TITLE: 06/10/2009 BCS WRID Don A Mackey

4152394

SCOTT AND WHITE MRN: 4152394
Bryan-College Station
Work Related Injury Report
SSN:
DOB:
DATE OF SERVICE: 06/10/2009

DATE OF INJURY:
June 5, 2009

EMPLOYER:
Texas A and M University.

JOB:
Ph.D. research scientist in the veterinary medicine school.

PLACE OF INJURY:
On the job.

NARRATIVE:
The patient is a 31-year-old Ph.D. research scientist, who was seen in the urgent care clinic by Dr. Thomas K Welch on June 5, 2009, after having a potential exposure to brucellosis. Dr. Welch felt that it was in the best interest to place the patient on antibiotics, and patient was started on antibiotics in the form of doxycycline 100 mg p.o. b.i.d. and rifampin 300 mg p.o. b.i.d.

Brucellosis titer was obtained and was negative. Patient is seen today for consultation regarding the exposure.

MEDICATIONS:
Patient is currently only on birth control pills in the form of Micronor; no other medications.

209-0538-06 KB

SOCIAL HISTORY:
She is a nonsmoker. The patient has 2 children, ages 9 months and 2 years. She grew up in the New York City area and came to Texas approximately 10 years ago.

She denies any previous difficulties with exposure. She does have livestock in the form of goats and a miniature donkey, and states she has had no ill animals at home.

REVIEW OF SYSTEMS:
Denies fever or chills, and has had no difficulty with any systemic complaints.
Review of systems otherwise negative.

PHYSICAL EXAMINATION:
VITAL SIGNS: Blood pressure 100/67, pulse 76, respirations 20. Weight 107 pounds.
GENERAL: The patient is an alert, bright, pleasant female in no acute distress.
HEENT: Shows pupils are equal and reactive. EOMs are intact. Fundi are clear. TMs are clear. Mucous membranes of the mouth are moist, well hydrated. No lesions are noted. Cranial nerves are intact.
NECK: No adenopathy, thyromegaly or bruits.
LUNGS: Clear.
CARDIAC: Normal S1 and S2. No murmurs or irregularities.
LYMPHATICS: The patient has no evidence of axillary adenopathy. There is no evidence of inguinal adenopathy, or popliteal adenopathy.
ABDOMEN: Soft, concave. No masses or tenderness. There is no evidence of hepatosplenomegaly. Bowel sounds are quite active.
EXTREMITIES: No cyanosis or edema. There are no evidence of skin lesions or other abnormalities present.

IMPRESSION:
Low-risk exposure to brucellosis.

DISPOSITION:
Patient indicates that she did not get the antibiotics filled as she did not feel they were indicated, and at this point in time, in view of the low risk, I do concur. I feel we can wait until she has her followup brucellosis titer in 4 weeks to determine if there was a distinct exposure present.

If there is a significant change in her titer, then certainly the antibiotics would be justified. She is aware of this. Approximately 30 minutes was spent today with the patient answering her questions, and addressing her concerns.

Electronically signed by
Don A Mackey, MD 06/12/2009

2006-0538-06 KB

SCOTT & WHITE

Name:
MRN: 4152394
DOB:

Printed 06/12/2009 09:27 by Candace Slightom
TITLE: 06/05/2009 BCS WRID Thomas Kenneth Welch

4152394

SCOTT AND WHITE MRN: 4152394
Bryan-College Station
Work Related Injury Report
SSN:
DOB: 12/09/1977
DATE OF SERVICE: 06/05/2009

EMPLOYER:
Texas A and M University

DATE OF INJURY:
June 5, 2009

CHIEF COMPLAINT:
Exposure to Brucella.

The patient is a 31-year-old female who works in the Texas A and M lab, which deals with different bacteria. There was 1 bag of trash, which was potentially in a non-clean room that found its way to the hallway where she apparently walked through. The supervisor there suggested that she may have touched the bag, but she does not recall doing that. She did have Brucella titers done actually last week as a routine part of her job. She is 9 months postpartum and is on progestin-only birth control pills. She has no significant medical illnesses.

PAST MEDICAL HISTORY:
Generally noncontributory.

ALLERGIES:
Questionable doxycycline, states that she became very nauseated after taking some doxycycline after having a dental extraction. She only took a couple of doses, but quit taking them because of the nausea. She does not describe any anaphylactic type shock.

2009 0538.04
KB

EXAM:
VITAL SIGNS: Temp 96.5, pulse 67, respirations 18, blood pressure 105/60. Weight is 109 pounds.

ASSESSMENT AND PLAN:
Exposure to brucellosis. Since exposure was today, no specific signs or symptoms would be present. I think the relative potential likelihood of exposure would have been very low, but due to the fact that treatment would need to be 6 weeks and probably started more abruptly, I recommend going ahead and doing oral treatment at this time with doxycycline and rifampin. We have prescribed her doxycycline 100 mg 1 p.o. b.i.d. with rifampin 300 mg 1 p.o. b.i.d. I wrote for a 3-week supply with a 3-week refill.

The patient was seen at approximately 5:15 on a Friday afternoon. I recommended at the present time going ahead and empirically starting treatment with the thought any further decisions on treatment to start, withhold based upon exposure could be handled by the Occupational Medicine department. We will try to get her followed by Dr. Mackey, hopefully within 1 to 2 weeks, since he is here on a limited basis.

We discussed that her side effect probably was not an allergic reaction, but potentially a side effect from the medicine, but I recommended going ahead and attempting to try it since it is the weekend with eating a reasonably decent meal ahead of time and if she were to develop significant gastrointestinal symptoms, then stop the medication and call Occupational Medicine department on Monday to determine any further treatment options or actions at that time. The patient denies the possibility of being pregnant at this time. I did mention that antibiotics would affect her birth control pills and use a separate form of barrier form of contraception while taking the antibiotics. Did discuss side effect of urine turning orange with the rifampin.

Electronically signed by
Thomas Kenneth Welch, MD
06/09/2009 10:23
Thomas Kenneth Welch, MD
125 /27940
979-691-3802
dd: 06/05/2009 6:02 P dt: 06/05/2009 8:10 P
Job #: 000717451 / 11579431 /
Doc ID#: 200906050992642700

cc:

WORKERS' COMPENSATION
INITIAL STATUS OF CLAIM REPORT

To:	**Bob Hensz** **Texas AgriLife Research**	Date: RE:	**06/30/09**
		Employed By Supervisor: D.O.I.: Claim No.:	**AgriLife Research** **Thomas Ficht** **06/05/2009** **209-0538-06**

PLEASE USE THE INFORMATION BELOW AS YOU DEEM NECESSARY

☐ We have received a medical bill/report that indicates an injury may have occurred on . Please verify with your records. If an injury occurred forward a copy of the Employer's First Report of Injury or your incident/accident report so we may timely process the medical bill. If an injury has not been reported, please notify this office, in writing, as soon as possible. ***If a response is not received within 3 days of receipt of this notice the claim for compensability will be accepted.***

☐ The employer's First Report of Injury has been received. Weekly compensation benefits will begin after the seven day waiting period pursuant to the Texas Workers' Compensation Act if disability continues **unless a Supplemental Report of Injury is received indicating the employee has returned to work or unless the Request for Paid Leave is received indicating that the employee will use sick and or annual leave.** A wage statement is required if the employee is disabled for more than eight days, even if the employee is using sick/annual leave of FMLA leave.

☒ This claim has been accepted as a compensable injury.

☐ This is a questionable claim. However, sufficient evidence does not exist at this time to contest compensability. Please provide us with written witness statements, and any other objective information that would assist us in making a determination of compensability.

☐ This claim has been denied because:
- ☐ There was no injury in course and scope of employment
- ☐ The injury was not sustained in the course & scope of employment
- ☐ Untimely notice of injury was given
- ☐ The injury is considered an ordinary disease of life
- ☐ Disability only, medical documentation required to establish physical harm
- ☐ Other:

☐ Other:
Thanks.

Please direct any questions regarding this claim and the above information to:

The Texas A&M University System
Office of Risk Management & Safety
College Station, TX 77845-3424
Phone: 979/458-6330 Fax: 979/458-6247

Adjuster: Kaye Ball
F:wci,procedure;office

TAMUS DEPT VOUCHER NO 261010# 51331

STATE OF TEXAS PURCHASE VOUCHER

Agency			Agency Voucher No
TEXAS A&M UNIVERSITY SYSTEM College Station,TX 77840		Order Date 07/14/2009	Requisition No NONE
	Invoice Date 07/14/2009	Voucher Amount $201.57	Payee Reference No NONE
			Control No NONE

Comptroller Vendor ID No		Agency Object	Amount
1742958277	NONE	6462	$201.57 E N C

Pay To (Name, Address, City, State, Zip)
SCOTT & WHITE
P.O. BOX 847408
DALLAS, TX 75284-7408

Account Name	TOTAL
Workers's Compensations Ins.	$201.57

ENCUMBRANCE LEDGER

Requisition No	Amount

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	Amount
06/10/2009 - 06/10/2009	209053806	$201.57

VENDOR CERTIFICATION
(Use when no invoice is available)
I certify the described articles or services were contracted for and the account is true,correct and unpaid

SIGNATURE

AGENCY CERTIFICATION
I certify that the above services were rendered,or goods received and that they correspond in every particular with contract under which they were procured and that the invoice is true and unpaid

DATE APPROVED FOR PAYMENT

NAME (PERSON RECEIVING GOODS)	DATE 07/14/2009	NAME
NAME (DEPT HEAD)	DATE 07/14/2009	TITLE

DWC #

Carrier's Claim # 209053806

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of injury
		06/05/2009

4. Injured employee's mailing address (Street or P.O. Box)	5. Employer's name and address
	Texas Agricultural Experiment Station Wells Fargo Building 3000 Briarcrest Drive Suite 504, Bryan, TX 77802
6. Health care provider's name and address SCOTT & WHITE P.O. BOX 847408, DALLAS, TX 75284-7408	7. Insurance carrier's name and address The Texas A&M University System 200 Technology Way, Suite 1120, College Station, TX 77845
8. Health care provider's federal tax I.D. number 742958277	Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s).
9. Name and address of the company performing the audit Starr Comprehensive Solutions, Inc. P.O. Box 801464, Houston, TX 77280-1464	Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be a compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act.
Date of the audit: 07/10/2009	ITN Number: 00275744
10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc. Phone: 866-462-4197 Fax: 713-462-4143	

RECEIVED
2009 JUL 14 AM 10:09
OFFICE OF RISK MANAGEMENT

ICD9 Codes used: 994.9 - OTHER EFFECTS OF EXTERNAL CAUSES

Dates of Service From Date	Thru Date	Procedure Code and Description	Modifier	Units	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
06/10/2009	06/10/2009	99204 OFFICE/OP VISIT, NEW PT, 3 KEY COMPONENTS:COMPREHENSIVE HX;COMPREHENSIVE		1.00	$271.00	$201.57	$0.00	$201.57	W1
			Totals:		**$271.00**	**$201.57**	**$0.00**	**$201.57**	

Reason for Reduction or Denial:
W1 - Workers Compensation State Fee Schedule Adjustment

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

WORKERS COMPENSATION
TEXAS A&M UNIVERSITY
200 TECHNOLOGY #1120
COLLEGE STATION, TX 77840

WC1

PICA

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER [X] (ID)

1a. INSURED'S I.D NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
TAMU,

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)
~~200 TECHNOLOGY 1120~~

CITY | STATE
TX

8. PATIENT STATUS
Single [ ] Married [ ] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY
COLLEGE STATION | STATE
TX

ZIP CODE | TELEPHONE (Include Area Code)
( )

ZIP CODE
77840 3 | TELEPHONE (Include Area Code)
(979) 458-6330

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
209-0538-06 KB

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous)
[X] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. AUTO ACCIDENT? PLACE (State)
[ ] YES [X] NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT?
[ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME
WORKERS COMPENSATION

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
[ ] YES [X] NO If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY
06/05/09

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. X5
17b. NPI 1366403552

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. 9949
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF NO

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID #
1 06/10/09	06/10/09	11		99204		1	271 00	1		NPI	MDE1032TX 201.57
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX ID NUMBER SSN EIN
742958277 X

26. PATIENT'S ACCOUNT NO
916700832B4Q0

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
[X] YES [ ] NO

28. TOTAL CHARGE
$ 271 00

29. AMOUNT PAID
$ 201.57

30. BALANCE DUE
$ 271 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
MACKEY, DON A MD
Signature on File
SIGNED 06/16/09 DATE

32. SERVICE FACILITY LOCATION INFORMATION
CS SCOTT AND WHITE
1600 UNIVERSITY DR EAST
COLLEGE STATION TX 77840
a 1922061993 b TJ 742958277

33. BILLING PROVIDER INFO & PH #
SCOTT AND WHITE
PO BOX 847408
DALLAS TX 752847408
(254) 724 2911
a 1922061993 b 7/14/09 DN

NUCC Instruction Manual available at www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08 05)

PAGE 001 MDE1032TX

NCMS-1500CS

Hammond SO -11-012-013
TAMUS 0103

TAMUS DEPT VOUCHER NO 261010# 51330

STATE OF TEXAS PURCHASE VOUCHER

Agency			Agency Voucher No
TEXAS A&M UNIVERSITY SYSTEM College Station,TX 77840		Order Date 07/14/2009	Requisition No NONE
	Invoice Date 07/14/2009	Voucher Amount $179.95	Payee Reference No NONE
			Control No NONE

Comptroller Vendor ID No		Agency Object	Amount
1621770924	NONE	6462	$179.95 E N C

Pay To (Name, Address, City, State, Zip)
STONERIVER - PHARMACY SOLUTIONS
PO BOX 100994
ATLANTA, GA 30384

Account Name	TOTAL
Workers's Compensations Ins.	$179.95

ENCUMBRANCE LEDGER

Requisition No	Amount

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	Amount
06/07/2009 - 06/07/2009	209053806	$179.95

VENDOR CERTIFICATION
(Use when no invoice is available)
I certify the described articles or services were contracted for and the account is true,correct and unpaid.

SIGNATURE

AGENCY CERTIFICATION
I certify that the above services were rendered,or goods received and that they correspond in every particular with contract under which they were procured and that the invoice is true and unpaid

DATE APPROVED FOR PAYMENT

NAME (PERSON RECEIVING GOODS)	DATE	07/14/2009	NAME
NAME (DEPT HEAD)	DATE	07/14/2009	TITLE

DWC #

Carrier's Claim # 209053806

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of Injury
		06/05/2009

4. Injured employee's mailing address (Street or P.O. Box)

5. Employer's name and address
Texas Agricultural Experiment Station
Wells Fargo Building 3000 Briarcrest Drive Suite 504, Bryan, TX 77802

6. Health care provider's name and address
STONERIVER - PHARMACY SOLUTIONS
PO BOX 100994, ATLANTA, GA 30384

7. Insurance carrier's name and address
The Texas A&M University System
200 Technology Way, Suite 1120, College Station, TX 77845

8. Health care provider's federal tax I.D. number
621770924

9. Name and address of the company performing the audit
Starr Comprehensive Solutions, Inc.
P.O. Box 801464, Houston, TX 77280-1464

Date of the audit: 07/10/2009

10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc.
Phone: 866-462-4197 Fax: 713-462-4143

Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s).

Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act.

ITN Number: 00275475

RECEIVED
2009 JUL 13 PM 2:56
TEXAS DEPT. OF INSURANCE
DIVISION OF WORKERS' COMP.
RISK MANAGEMENT

Date / Rx. # / NDC # / Product/Strength	Day Supply	Which Refill #	Generic Drug	Quantity / Doctor	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
06/07/2009 69628 53489011902	21	1	Yes	42.00	$74.45	$74.45	$0.00	$74.45	
				THOMAS WELCH					
06/07/2009 69628 00527131530 RIFAMPIN/300 MG	21	0	Yes	42.00	$105.50	$105.50	$0.00	$105.50	
				THOMAS WELCH					
				Totals:	$179.95	$179.95	$0.00	$179.95	

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION STATEMENT OF PHARMACY SERVICES

Send this form to the injured employee's workers' compensation insurance carrier.

Coverage Verification

☒ In accordance with Rule 134.501, I affirm that I have verified the workers' compensation insurance coverage for this employer, confirmed that a work-related injury of the employee named below has been reported to the employer for the listed date of injury, and have kept documentation regarding the means of verification/confirmation on file. (See DCW FORM-66 Instructions for the Verification Statement.)

Section 1

1. Pharmacy's Name, Address, and Phone #:
KROGER PHARMACY
2303 BOONVILLE RD
BRYAN, TX 77808-2232
Phone (979) 774-8377
Fax

2. Date of Billing:
06/21/09

3. Pharmacy's NCPDP #: (NPI #):
4561228 1821161357

4. Remit Payment To (if different from above):
StoneRiver - Pharmacy Solutions
P.O. BOX 100994
ATLANTA, GA 30384-0994

5. Invoice #:
29704326

6. Payee's FEIN:
62-1770924

7. Carrier's Name and Address:
TEXAS A & M UNIVERSITY SYSTEM
ATTN: KAYE BALL
200 TECHNOLOGY WAY STE 1120
COLLEGE STATION, TX 77845-3424

8. Employer's Name, Address, and Phone #:
TEXAS A & M UNIVERSITY
200 TECHNOLOGY WAY
COLLEGE STATION, TX 77845-3424
(979) 845-4141

9. Injured Employee's Name, Address, and Phone #:

15. Prescribing Doctor's Name, Address, and Phone #:
WELCH THOMAS KENNETH MD
1600 UNIVERSITY DR E
COLLEGE STATION, TX 77840-2
(979) 691-3300

16. Prescribing Doctor's DEA#: (NPI #):
BW3188023 1720040

14. Carrier's Claim # (If known):
~~20483230L~~
209-0538-06

10a. Injured Employee's ID #

10b. ID Jurisdiction
U.S.

10c. ☒ SSN ☐ DL# ☐ Passport ☐ Visa ☐ Green Card

11. DOI:
06/05/09

12. DOB:

13. Claim # (If known):

RECEIVED
2009 JUN 29 AM 11:18
TEXAS MUTUAL INSURANCE COMPANY RISK MANAGEMENT

Section 2

17	18	19	20	21	22	23	24	25	26	27	28	29
☒ Generic Dispensed ☐ Name Brand Dispensed	Generic Available? ☐ YES ☐ NO	☐ Dispensed as Written ☐ Dispensed per Injured Employee request	Date filled:	Generic NDC:	Name Brand NDC:	Quantity:	Days Supply:	Refills Remaining:	Paid by Employee:	Drug Name and Strength:	Rx #:	Amount Billed:
			06/07/09	53489011902		42.000	21	1		DOXYCYCL HYC CAP 100MG	6962841	74.45
☒ Generic Dispensed ☐ Name Brand Dispensed	Generic Available? ☐ YES ☐ NO	☐ Dispensed as Written ☐ Dispensed per Injured Employee request	Date filled:	Generic NDC:	Name Brand NDC:	Quantity:	Days Supply:	Refills Remaining:	Paid by Employee:	Drug Name and Strength:	Rx #:	Amount Billed:
			06/07/09	00527131530		42.000	21	0		RIFAMPIN CAP 300MG	6962842	105.50
☐ Generic Dispensed ☐ Name Brand Dispensed	Generic Available? ☐ YES ☐ NO	☐ Dispensed as Written ☐ Dispensed per Injured Employee request	Date filled:	Generic NDC:	Name Brand NDC:	Quantity:	Days Supply:	Refills Remaining:	Paid by Employee:	Drug Name and Strength:	Rx #:	Amount Billed:

7/14/09 ON

INVOICE # 29704326 TOTAL 179.95

TAMUS DEPT VOUCHER NO 261010# 51159

STATE OF TEXAS PURCHASE VOUCHER

Agency TEXAS A&M UNIVERSITY SYSTEM College Station,TX 77840			Agency Voucher No	
		Order Date 07/09/2009	Requisition No NONE	
	Invoice Date 07/09/2009	Voucher Amount $89.26	Payee Reference No NONE	Control No NONE

Comptroller Vendor ID No 1742958277 NONE	Agency Object	Amount
Pay To (Name, Address, City, State, Zip) SCOTT & WHITE P.O. BOX 847408 DALLAS, TX 75284-7408	6462	$89.26 E N C
Account Name Workers's Compensations Ins.	TOTAL	$89.26

ENCUMBRANCE LEDGER	
Requisition No	Amount

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	Amount
06/05/2009 - 06/05/2009	209053806	$89.26

VENDOR CERTIFICATION
(Use when no invoice is available)
I certify the described articles or services were contracted for and the account is true,correct and unpaid.

SIGNATURE

AGENCY CERTIFICATION
I certify that the above services were rendered,or goods received and that they correspond in every particular with contract under which they were procured and that the invoice is true and unpaid

DATE APPROVED FOR PAYMENT

NAME (PERSON RECEIVING GOODS)	DATE	07/09/2009	NAME	
NAME (DEPT HEAD)	DATE	07/09/2009	TITLE	

DWC #

Carrier's Claim # 209053806

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of injury
		06/05/2009

4. Injured employee's mailing address (Street or P.O. Box)	5. Employer's name and address
	Texas Agricultural Experiment Station Wells Fargo Building 3000 Briarcrest Drive Suite 504, Bryan, TX 77802
6. Health care provider's name and address SCOTT & WHITE P.O. BOX 847408, DALLAS, TX 75284-7408	7. Insurance carrier's name and address The Texas A&M University System 200 Technology Way, Suite 1120, College Station, TX 77845
8. Health care provider's federal tax I.D. number 742958277	Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s).
9. Name and address of the company performing the audit Starr Comprehensive Solutions, Inc. P.O. Box 801464, Houston, TX 77280-1464	Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act.
Date of the audit: 07/08/2009	ITN Number: 00276451
10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc. Phone: 866-462-4197 Fax: 713-462-4143	

RECEIVED
2009 AUG 18 P 3:31
OFFICE OF PRISONER REPRESENTATION

ICD9 Codes used: 987.9 - TOXIC EFFECT OF UNSPECIFIED GAS FUME OR VAPOR

Dates of Service From Date	Thru Date	Procedure Code and Description	Modifier	Units	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
06/05/2009	06/05/2009	99202		1.00	$120.00	$89.26	$0.00	$89.26	W1
		OFFICE/OP VISIT, NEW PT, 3 KEY COMPONENTS: EXPAND PROB FOCUS HX; EXPAND PROB FOC							
				Totals:	$120.00	$89.26	$0.00	$89.26	

Reason for Reduction or Denial:
W1 - Workers Compensation State Fee Schedule Adjustment

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

WORKERS COMPENSATION
TEXAS A&M UNIVERSITY
200 TECHNOLOGY #1120
COLLEGE STATION, TX 77840

WC1

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial) TAMU,

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street) ~~200 TECHNOLOGY 1120~~

CITY | STATE

8. PATIENT STATUS Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY COLLEGE STATION | STATE TX

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE 77843 | TELEPHONE (Include Area Code) (979) 458-6330

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER 209-0638 06 KP

a. EMPLOYMENT? (Current or Previous) [X] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME WORKERS COMPENSATION

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 06/05/09

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. XS

17b. NPI 1720040637

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 9879

2.

3.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
1 06/05/09	06/05/09	11		99202		1	120 00	1		NPI	1720040637
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 742958277 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO: 916100441B4Q0

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 120 00

29. AMOUNT PAID: $ 89.26

30. BALANCE DUE: $ 120 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

WELCH, THOMAS

Signature on File MD 06/10/09

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

CE BCS URGENT CARE
1600 UNIVERSITY DR EAST
COLLEGE STATION TX 77840

a 1093779704 b TJ 742958277

33. BILLING PROVIDER INFO & PH #

SCOTT AND WHITE
PO BOX 847408
DALLAS TX 752847408
(254) 724-2911

a 1922061993 b 7/9/09 DN

NUCC Instruction Manual available at www.nucc.org

APPROVED OMB 09 38 0999 FORM CMS-1500 (08/05)

PAGE 001

MDJ0356TX

WCMS-1500CS

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2009 JUN 23 PM 1:11
OFFICE OF RISK MANAGEMENT

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV, WHCF-10-ENV-SS

CARRIER

Hammond SO -11-012-013
TAMUS 0109

CHECK LIST FOR NEW FOLDERS

- ☐ Prepare lost time chart
- ☑ Acceptance Letter
- ☐ Contact injured employee for statement by telephone (date _____)
- ☑ Employer initial status of claim (date 6/30/09) left msg - 6/30/09
  - ☐ Wage statement
  - ☐ Request for Paid Leave
  - ☐ Supplemental
  - ☐ Request emailed on _____
- ☑ Initial questionnaire to Claimant
- ☐ Work status tracking log
- ☐ Copy of work status to employer
- ☐ Update work status in Allegro
- ☑ Update claim notes for extent of injury & controverted
- ☐ PLN ☐1 _____ ☐2 _____ ☐6 _____ ☐11 _____
- ☐ EDI 1st report Did Salary Continue? Y or N _____
- ☐ DWC Record Check
- ☐ Request witness statement
- ☐ COMP Divider
- ☑ Diary
  - ☑ PLN 11 (define extent of injury within first 60 days)
  - ☐ 8th day, elimination week, 26 weeks, & FMLA ends

Subrogated claim:

- ☐ Notice to claimant
- ☐ Notice to 3rd party
- ☐ Notice to 3rd party insurance
- ☐ Request accident report

Work status change:

- ☐ Update lost time in Allegro
- ☐ Update work status tracking log
- ☐ Copy of work status to Employer

Impairment benefits:

- ☐ PLN 3
- ☐ Update Allegro MMI/IR
- ☐ Subsequent Status Claim Form to Employer
- ☐ Request Wage Statement

Revised 7/05

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Toll Free: 866-249-8574 • Fax 979-458-6247 • http://tamusystem.tamu.edu

NOTICE OF DISPUTED ISSUE(s) AND REFUSAL TO PAY BENEFITS

DATE: August 14, 2009

TO: NAME OF INJURED EMPLOYEE:
ADDRESS:
CITY, STATE, ZIP:

FAXED TO STARR
DATE: 8/14/09

RE: DATE OF INJURY: 06/05/2009
NATURE OF INJURY: Possibe Exposure to Brucella
PART OF BODY INJURED: Body
EMPLOYEE SSN:
DWC #: Unknown
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 209-0539-06
EMPLOYER NAME: Texas AgriLife Research
EMPLOYER ADDRESS: 3000 Briarcrest Drive, Ste 504
EMPLOYER CITY, STATE, ZIP: Bryan, TX 77802

We are disputing entitlement of any body part, medical condition, or diagnosis other than a possible exposure to brucella, only because:

The Texas A&M University System as the workers' compensation insurance carrier for Texas AgriLife Research accepts that the compensable injury extends to and includes a possible exposure to brucella, only, that occurred on or about 06/05/2009. Carrier disputes that the compensable injury extends to and includes any and all other body parts and/or medical conditions. If further evidence is presented our decision will be reviewed.

If you do not agree with the dispute and refusal to pay benefits, please contact me:

Adjuster's Name: **Kaye Ball**
Toll Free Telephone #: **1-866-249-8574**
Fax #/E-mail Address: **1-979-458-6247/KBall@tamu.edu**

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. Contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

Cc: DWC, 7551 Metro Center Drive, Ste. 100, Austin, Texas 78744-1645

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2139
RECIPIENT ADDRESS	917134624143
DESTINATION ID	
ST. TIME	08/14 17:21
TIME USE	00'23
PAGES SENT	1
RESULT	OK

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Toll Free: 866-249-8574 • Fax 979-458-6247 • http://tamusystem.tamu.edu

NOTICE OF DISPUTED ISSUE(s) AND REFUSAL TO PAY BENEFITS

FAXED TO STARR
DATE: 8/14/09

DATE: August 14, 2009

TO: NAME OF INJURED EMPLOYEE:
ADDRESS:
CITY, STATE, ZIP:

RE: DATE OF INJURY: 06/05/2009
NATURE OF INJURY: Possibe Exposure to Brucella
PART OF BODY INJURED: Body
EMPLOYEE SSN:
DWC #: Unknown
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 209-0539-06
EMPLOYER NAME: Texas AgriLife Research
EMPLOYER ADDRESS: 3000 Briarcrest Drive, Ste 504
EMPLOYER CITY, STATE, ZIP: Bryan, TX 77802

We are disputing entitlement of any body part, medical condition, or diagnosis other than a possible exposure to brucella, only because:

The Texas A&M University System as the workers' compensation insurance carrier for Texas AgriLife Research accepts that the compensable injury extends to and includes a possible exposure to brucella, only, that occurred on or about 06/05/2009. Carrier disputes that the compensable injury extends to and includes any and all other body parts and/or medical conditions. If further evidence is presented our decision will be reviewed.

If you do not agree with the dispute and refusal to pay benefits, please contact me:

Adjuster's Name: Kaye Ball
Toll Free Telephone #: 1-866-249-8574
Fax #/E-mail Address: 1-979-458-6247/KBall@tamu.edu

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. Contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

INITIAL RESERVES
MEDICAL _____
INDEMNITY _____
LAE _____

LOST TIME Y/N ADJUSTER KB

CLAIM # _____

CARRIER'S CLAIM # 209-0539-06

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

2. Sex F ☒ M ☐

3. Social Security Number | 4. Home Phone | 5. Date of Birth (m-d-y)

6. Does the Employee Speak English? If No, Specify Language
YES ☒ NO ☐

7. Race White ☒ Black ☐ Asian ☐
8. Ethnicity Hispanic ☐ Native American ☐ Other ☒

9. Mailing Address Street or P.O. Box

City | State | Zip Code | County

10. Marital Status

11. Number of Dependent Children | 12. Spouse's Name

13. Doctor's Name DR. KELLY GRILLO

14. Doctor's Mailing Address (Street or P.O.Box)
SCOTT & WHITE CLINIC
1600 UNIVERSITY DRIVE EAST
City COLLEGE STATION State TX Zip Code 77840

15. Date of Injury (m-d-y) 06-05-2009
16. Time of Injury 10:00 am ☒ pm ☐
17. Date Lost Time Began (m-d-y) N/A

18. Nature of Injury* Potential exposure to agent
19. Part of Body Injured or Exposed* Total body

20. How and Why Injury/Illness Occurred*
Human error - entered room containing potential infective agent / gathered trash w/o PPE

21. Was employee doing his regular job? YES ☒ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)* Laboratory - Bldg 1149

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site
TAMU - VTPB - Bldg 1149
Street or P.O. Box MS #4467 County Brazos
City COLLEGE STATION State TX Zip Code 77843-4467

24. Cause of Injury(fall, tool, machine, etc.)* Human error - potential exposure to B. abortus agent

25. List Witnesses Melissa Kahl-McDonagh

26. Return to work date/or expected (m-d-y) N/A
27. Did employee die? YES ☐ NO ☒
28. Supervisor's Name Dr. L. Garry Adams
29. Date Reported (m-d-y) 06-05-2009

30. Date of Hire (m-d-y) 9-1-1978
31. Was employee hired or recruited in Texas? YES ☒ NO ☐
32. Length of Service in Current Position Months ____ Years 31
33. Length of Service in Occupation Months ____ Years 31

34. Employee Payroll Classification Code 9220
35. Occupation of Injured Worker Research Associate

36. Rate of Pay at this Job $3289.50/mo $____Hourly $____Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $3287.50 for ____ Hours or 21 Days
39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form
Betty Guerra
41. Name of Business
Vet Pathobiology

42. Business Mailing Address and Telephone Number
Street or P.O. Box Rm. 119. VMS
Telephone (979) 845-5944
City College Station State TX Zip Code 77843-4467
43. Business Location (if different from mailing address) Number and Street
City | State | Zip Code

44. Federal Tax Identification Number
45. Primary North American Industry Classification System Code: (6 digit)
46. Specific NAICS Code (6 digit)
47. Texas Comptroller Taxpayer No.

48. Workers' Compensation Insurance Company
49. Policy Number

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☒ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X Betty Guerra Date 6-10-09

RECEIVED
2009 JUN 22 PM 2:53
TAMU OFFICE OF RISK MANAGEMENT

DWC FORM-1 (Rev. 10/05) Page 3

entered 6/26/09

DIVISION OF WORKERS' COMPENSATION

INITIAL CLAIM QUESTIONNAIRE

Claimant:
Address:

Claim # 209-0539-06 KB
Date of Injury: 06/05/2009
Date mailed: 06/30/2009

Please complete, sign, and date this claims questionnaire and return in the enclosed postage paid envelope as soon as possible.

1. Did your injury occur while performing your normal job duties?

Yes

2. Please state in your own words where injury occurred.

I entered BSL3 in vmR Bldg #1194 without proper PPE. This room had potentially harmful agents inside.

3. Please state in your own words any physical harm or damage to your body that resulted from the work related incident.

None

4. Have you sought medical attention for this injury? If so please indicate your choice of primary care physician. Have you seen this physician in the past three years for other conditions whether work related or not.

I was sent to the Occupational Health doctor at Scott & White Day Care center. I have not seen this doctor before.

5. If you have multiple employers please list the name and address of each employer

NA

Injured employee signature

July 1, 2009
Date

c:inques

2009 JUL -6 P 2:09
TAMUS OFFICE OF RISK MANAGEMENT

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Fax 979-458-6247 • http://tamusystem.tamu.edu

June 26, 2009

Dear

This office is in receipt of a First Report of Injury indicating that you sustained a work-related injury on 6/5/2009.

Any medical bills you incur as a direct result of this injury should be immediately forwarded to this office for consideration. Prescription drugs may be filled at any pharmacy. Please do not use your health care insurance to have these prescriptions filled.

If you miss more than a day of work as result of this injury you must contact your department to ensure that you receive all the benefits to which you may be entitled.

If you have any questions regarding your claim, please come by our office or call us at (979) 458-6330.

Sincerely,

Kaye Ball

KAYE BALL
Workers' Compensation Insurance
Risk Management Division

Enclosure

MEDICAL SERVICES CHART

CLAIM# 209-053G-06

DOI: 6/5/09 Nature of Injury Potential Exposure to Bacteria

Body Part Injured Body / Body Systems

MMI DATE _____ %IMPAIRMENT _____

Treating Dr _____

Approved Change _____

Consulting/Referral (approval date)

_____

_____

RME _____ Date _____

Result _____

D/D _____ Date _____

Result _____

Initial Treatment Plan Initial Diagnosis Code _____

Secondary Treatment Plan or Changes

X-Ray
Body Part _____ Date _____ Result _____

MRI
Body Part _____ Date _____ Result _____

C/T Scan
Body Part _____ Date _____ Result _____

Bone Scan
Body Part _____ Date _____ Result _____

Myelogram
Body Part _____ Date _____ Result _____

EMG
Body Part _____ Date _____ Result _____

PHYSICAL THERAPY

WEEK 1 _____	WEEK 1 _____
WEEK 2 _____	WEEK 2 _____
WEEK 3 _____	WEEK 3 _____
WEEK 4 _____	WEEK 4 _____
WEEK 5 _____	WEEK 5 _____
WEEK 6 _____	WEEK 6 _____
WEEK 7 _____	WEEK 7 _____
WEEK 8 _____	WEEK 8 _____

COMMENTS: _____

SURGICAL PROCEDURES

_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

DENIED PHARMACY

PREAUTHORIZATIONS

DATE	YES/NO	PROCEDURE

BODY PART DENIED _____
DATE _____ TWCC 21 FILED Y/N
BODY PART DENIED _____
DATE _____ TWCC 21 FILED Y/N
BODY PART DENIED _____
DATE _____ TWCC 21 FILED Y/N
NOTES: _____

09-0539-06 KB

SCOTT & WHITE

Name:
MRN: 1171977
DOB:

Printed 06/17/2009 09:31 by Candace Slightom
TITLE: 06/05/2009 BCS Urgent Care Bruce A Hoekstra

1171977

SCOTT AND WHITE MRN: 1171977
Bryan-College Station Clinic Note

DOB:
DATE OF SERVICE: 06/05/2009

Today Care

A 56-year-old female patient who works in a veterinary pathology department at the Texas A and M Veterinary School. She reports that she has had a potential exposure to Brucella. She inappropriately handled a biohazard bag. The biohazard bag contained bovine products that might have Bruce. The case is not yet confirmed, but following the protocol of the university the patient is here today for evaluation. She has already had brucella titer baseline drawn. The patient is not concerned. She feels that even the potential exposure is minimal and since she has 37 years of experience working in the lab, she has had contact although through appropriate handling with products containing Brucella previously. Other review of systems is negative. The patient's general summary sheet in Sequoia 5 is reviewed and information there is noted.

PHYSICAL EXAMINATION:
GENERAL: This is a pleasant, generally healthy-appearing 56-year-old.
VITAL SIGNS: Temperature 98.9. Pulse 95. Respiratory rate 18. Weight 204 pounds. Blood pressure 141/97. Patient reports for her this is high because of having the concern about a protocols involved with potential Brucella exposed.
HEAD/EYES/EARS/NOSE/MOUTH/THROAT: No acute infection. The rest of the exam has no notable findings.

ASSESSMENT:
Potential Brucella exposure.

PLAN:
The nature and natural history of Brucella in humans is discussed with the patient. Generally this results in flu-type symptoms or arthralgias and myalgias. The patient should have a followup titer drawn in 2 weeks. This

209-0539-06 KB

is already planned. If there is a increase in titers she should consult again. Otherwise, she is reassured that the statistical probability based on general likelihood and probability of developing Brucella infection from what she described happened today is minimal. This is a workman's comp claim and the requisite paperwork is filled out.

Electronically signed by
Bruce A Hoekstra, MD 06/11/2009
14:46
Bruce A Hoekstra, MD
125 / 21467
979-691-3222
dd: 06/05/2009 5:14 P dt: 06/06/2009 2:40 P
Job #: 000717389 - 11582029 -
Doc ID#: 200906050992510300

cc:

INITIAL CLAIM QUESTIONNAIRE

Claimant:		Claim #	209-0539-06
Address:		Date of Injury:	06/05/2009
		Date mailed:	06/30/2009

Please complete, sign, and date this claims questionnaire and return in the enclosed postage paid envelope as soon as possible.

1. Did your injury occur while performing your normal job duties?

2. Please state in your own words where and how your injury occurred.

3. Please state in your own words any physical harm or damage to your body that resulted from the work related incident.

Read
7/6/09

4. Have you sought medical attention for this injury? If so please indicate your choice of primary care physician. Have you seen this physician in the past three years for other conditions whether work related or not.

5. If you have multiple employers please list the name and address of each employer

Injured employee signature _____ Date _____

c inques

WORKERS' COMPENSATION
INITIAL STATUS OF CLAIM REPORT

To:	**Bob Hensz**	Date:	**06/30/09**
	Texas AgriLife Research	RE:	
		Employed By	**AgriLife Research**
		Supervisor:	**Dr. L Garry Adams**
		D.O.I.:	**06/05/09**
		Claim No.:	**209-0539-06**

PLEASE USE THE INFORMATION BELOW AS YOU DEEM NECESSARY

☐ We have received a medical bill/report that indicates an injury may have occurred on . Please verify with your records. If an injury occurred forward a copy of the Employer's First Report of Injury or your incident/accident report so we may timely process the medical bill. If an injury has not been reported, please notify this office, in writing, as soon as possible. ***If a response is not received within 3 days of receipt of this notice the claim for compensability will be accepted.***

☐ The employer's First Report of Injury has been received. Weekly compensation benefits will begin after the seven day waiting period pursuant to the Texas Workers' Compensation Act if disability continues **unless a Supplemental Report of Injury is received indicating the employee has returned to work or unless the Request for Paid Leave is received indicating that the employee will use sick and or annual leave.** A wage statement is required if the employee is disabled for more than eight days, even if the employee is using sick/annual leave of FMLA leave.

☒ This claim has been accepted as a compensable injury.

☐ This is a questionable claim. However, sufficient evidence does not exist at this time to contest compensability. Please provide us with written witness statements, and any other objective information that would assist us in making a determination of compensability.

☐ This claim has been denied because:
- ☐ There was no injury in course and scope of employment
- ☐ The injury was not sustained in the course & scope of employment
- ☐ Untimely notice of injury was given
- ☐ The injury is considered an ordinary disease of life
- ☐ Disability only, medical documentation required to establish physical harm
- ☐ Other:

☐ Other:
Thanks.

Please direct any questions regarding this claim and the above information to:

The Texas A&M University System
Office of Risk Management & Safety
College Station, TX 77845-3424
Phone: 979/458-6330 Fax: 979/458-6247

Adjuster: Kaye Ball
F:wci,procedure;office

TAMUS DEPT VOUCHER NO 261010# 51221

STATE OF TEXAS PURCHASE VOUCHER

Agency TEXAS A&M UNIVERSITY SYSTEM College Station,TX 77840			Agency Voucher No	
		Order Date 07/13/2009	Requisition No NONE	
	Invoice Date 07/13/2009	Voucher Amount $89.26	Payee Reference No NONE	Control No NONE
Comptroller Vendor ID No 1742958277	NONE		Agency Object 6462	Amount $89.26 E N C
Pay To (Name, Address, City, State, Zip) SCOTT & WHITE P.O. BOX 847408 DALLAS, TX 75284-7408				
Account Name Workers's Compensations Ins.			TOTAL $89.26	

ENCUMBRANCE LEDGER	
Requisition No	Amount

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	Amount
06/05/2009 - 06/05/2009	209053906	$89.26

VENDOR CERTIFICATION
(Use when no invoice is available)
I certify the described articles or services were contracted for and the account is true,correct and unpaid.

SIGNATURE

AGENCY CERTIFICATION
I certify that the above services were rendered,or goods received and that they correspond in every particular with contract under which they were procured and that the invoice is true and unpaid

DATE APPROVED FOR PAYMENT

NAME (PERSON RECEIVING GOODS)	DATE	07/13/2009	NAME	
NAME (DEPT HEAD)	DATE	07/13/2009	TITLE	

DWC #

Carrier's Claim # 209053906

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of injury
		06/05/2009

4. Injured employee's mailing address (Street or P.O. Box)

5. Employer's name and address
Texas Agricultural Experiment Station
Wells Fargo Building 3000 Briarcrest Drive Suite 504, Bryan, TX 77802

6. Health care provider's name and address
SCOTT & WHITE
P.O. BOX 847408, DALLAS, TX 75284-7408

7. Insurance carrier's name and address
The Texas A&M University System
200 Technology Way, Suite 1120, College Station, TX 77845

8. Health care provider's federal tax I.D. number
742958277

9. Name and address of the company performing the audit
Starr Comprehensive Solutions, Inc.
P.O. Box 801464, Houston, TX 77280-1464

Date of the audit: 07/09/2009

10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc.
Phone: 866-462-4197 Fax: 713-462-4143

Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s).

Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act.

ITN Number: 00275746

RECEIVED
JUL 13 2009
TAMUS RISK MANAGEMENT OFFICE

ICD9 Codes used: 987.9 - TOXIC EFFECT OF UNSPECIFIED GAS FUME OR VAPOR

Dates of Service From Date	Thru Date	Procedure Code and Description	Modifier	Units	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
06/05/2009	06/05/2009	99202 OFFICE/OP VISIT, NEW PT, 3 KEY COMPONENTS: EXPAND PROB FOCUS HX; EXPAND PROB FOC		1.00	$120.00	$89.26	$0.00	$89.26	W1
		Totals:			**$120.00**	**$89.26**	**$0.00**	**$89.26**	

Reason for Reduction or Denial:
W1 - Workers Compensation State Fee Schedule Adjustment

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

WORKERS COMPENSATION
TEXAS A&M UNIVERSITY
200 TECHNOLOGY #1120
COLLEGE STATION, TX 77840

WC1

PICA

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F X	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
		TAMU,
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
		~~200 TECHNOLOGY 1120~~
CITY / STATE	8. PATIENT STATUS Single Married Other	CITY / STATE
		COLLEGE STATION / TX
ZIP CODE / TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student	ZIP CODE / TELEPHONE (Include Area Code)
		77840 3 / (979) 458-6330

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
209-0539-06		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) X YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
		WORKERS COMPENSATION
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
06/05/09		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. X5 / 17b. NPI 1598725871	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1,2,3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
1. L.9879 3.		23. PRIOR AUTHORIZATION NUMBER
2. 4.		

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID #
1 06/05/09 06/05/09	11		99202		1	120 00	1		0B	MDG6941TX
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
742958277 X	916701149B4Q0	X	$ 120 00	$ 89.26	$ 120 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

HOEKSTRA, BRUCE A MD

Signature on File 06/16/09

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

CE BCS URGENT CARE
1600 UNIVERSITY DR EAST
COLLEGE STATION TX 77840

a 1093779704 b TJ 742958277

33. BILLING PROVIDER INFO & PH #

SCOTT AND WHITE
PO BOX 847408
DALLAS TX 752847408
(254) 724-2911

a 1922061993 b 7/13/09 DN

NUCC Instruction Manual Available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

PAGE 001 MDG6941TX

NCMS-1500CS

Hammond SO -11-012-013
TAMUS 0123

CHECK LIST FOR NEW FOLDERS

- ☐ Prepare lost time chart
- ☐ Acceptance Letter
- ☐ Contact injured employee for statement by telephone: date-_____
- ☑ Employer initial status of claim (blue sheet)
  - ☐ Wage statement
  - ☐ Request for Paid Leave
  - ☐ Supplemental
  - ☑ Emailed on 8/27/09
- ☐ Initial questionnaire to Claimant
- ☐ Work status tracking log
- ☐ Copy of work status to employer
- ☑ Update work status in Allegro
- ☑ Update claim notes for extent of injury & controverted
- ☑ PLN ☒1 ☐2 ☐6 ☐11
- ☐ EDI 1st report (LWOP not using sick/annual leave) _____
- ☐ DWC Record Check
- ☐ Request witness statement
- ☐ COMP Divider
- ☐ Diary
  - ☐ PLN 11 (defined Extent of Injury within 60 days)
  - ☐ 8th Day of Disability, Elimination Week & Week 26

Subrogated claim:

- ☐ Notice to claimant
- ☐ Notice to 3rd party
- ☐ Notice to 3rd party insurance
- ☐ Request accident report

Work status change:

- ☐ Update lost time in Allegro
- ☐ Update work status tracking log
- ☐ Copy of work status to Employer

Impairment benefits:

- ☐ EDI 1st report
- ☐ PLN 3
- ☐ Update Allegro MMI/IR
- ☐ Subsequent Status Claim form to Employer

Request wage statement?

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Toll Free: 866-249-8574 • Fax 979-458-6247 • http://tamusystem.tamu.edu

NOTICE OF DENIAL OF COMPENSABILITY/LIABILITY AND REFUSAL TO PAY BENEFITS

DATE: March 2, 2009

TO: NAME OF INJURED EMPLOYEE:
ADDRESS:
CITY, STATE, ZIP:

FAXED TO STARR
DATE 3/3/09 RS

RE: DATE OF INJURY: 02/02/2009
NATURE OF INJURY: exposure to tuberculosis
PART OF BODY INJURED: whole body
EMPLOYEE SSN:
DWC #: Unassigned
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 209-0291-02
EMPLOYER NAME: Texas A&M University
EMPLOYER ADDRESS: General Services Complex, Ste. 1201
EMPLOYER CITY, STATE, ZIP: College Station, TX 77843-1255

On February25, 2009 we received notice that you reported an on the job injury. We are denying your claim for workers' compensation benefits. Workers' compensation benefits, including medical benefits, are not being paid because:

The Texas A&M University System as the workers' compensation insurance carrier for the Texas A&M University denies compensability/liability for the exposure to tuberculosis that occurred on or about 02/02/2009. Exposure in and of itself would not be considered an injury in course and scope of employment, absent physical harm or damage to the body nor an occupational disease absent an illness resultant from the exposure. If further evidence is presented, it will be reviewed.

If you do not agree with the denial and refusal to pay benefits, please contact me:

Adjuster's Name: Kaye Ball
Toll Free Telephone #: 1-866-249-8574
Fax #/E-mail Address: 1-979-458-6247/KBall@tamu.edu

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. Contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

Cc: DWC, 7551 Metro Center Drive, Ste. 100, Austin, Texas 78744-1645

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	1178
RECIPIENT ADDRESS	917134624143
DESTINATION ID	
ST. TIME	03/03 17:05
TIME USE	00'27
PAGES SENT	1
RESULT	OK

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Toll Free: 866-249-8574 • Fax 979-458-6247 • http://tamusystem.tamu.edu

NOTICE OF DENIAL OF COMPENSABILITY/LIABILITY AND REFUSAL TO PAY BENEFITS

DATE: March 2, 2009

TO: NAME OF INJURED EMPLOYEE:
ADDRESS:
CITY, STATE, ZIP:

FAXED TO STARR
DATE: 3/3/09 MS

RE: DATE OF INJURY: 02/02/2009
NATURE OF INJURY: exposure to tuberculosis
PART OF BODY INJURED: whole body
EMPLOYEE SSN:
DWC #: Unassigned
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 209-0291-02
EMPLOYER NAME: Texas A&M University
EMPLOYER ADDRESS: General Services Complex, Ste. 1201
EMPLOYER CITY, STATE, ZIP: College Station, TX 77843-1255

On February25, 2009 we received notice that you reported an on the job injury. We are denying your claim for workers' compensation benefits. Workers' compensation benefits, including medical benefits, are not being paid because:

The Texas A&M University System as the workers' compensation insurance carrier for the Texas A&M University denies compensability/liability for the exposure to tuberculosis that occurred on or about 02/02/2009. Exposure in and of itself would not be considered an injury in course and scope of employment, absent physical harm or damage to the body nor an occupational disease absent an illness resultant from the exposure. If further evidence is presented, it will be reviewed.

If you do not agree with the denial and refusal to pay benefits, please contact me:

Adjuster's Name: Kaye Ball
Toll Free Telephone #: 1-866-249-8574
Fax #/E-mail Address: 1-979-458-6247/KBall@tamu.edu

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. Contact the Division office handling your claim at 1-800-252-7031.

02-20-09;22:39 ;

7-8546

Rec'd 2/25/09
8/8

02

Amended Copy

INITIAL RESERVES
MEDICAL _____
INDEMNITY _____
LAE _____

LOST TIME Y/N ADJUSTER KB pensation,

CLAIM # _____

CARRIER'S CLAIM # 209-0291-02

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☑ M ☐

3. Social Security Number | 4. Home Phone | 5. Date of Birth (m-d-y)

6. Does the employee speak English? If No, Specify Language
YES ☑ NO ☐

7. Race White ☑ Black ☐ Asian ☐

8. Ethnicity Hispanic ☐ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

10. Marital Status

11. Number of Dependent Children | 12. Spouse's Name

13. Doctor's Name

14. Doctor's Mailing Address (Street or P.O.Box)

City State Zip Code

15. Date of Injury (m-d-y) 11-21-08 10-22-08 2-2-09

16. Time of Injury : am ☐ pm ☐

17. Date Lost Time Began (m-d-y) NLT - -

18. Nature of Injury* possible exposure

19. Part of Body Injured or Exposed* bird has mycobacterium tuberculosis

20. How and Why Injury/Illness Occurred* in same room as samples

21. Was employee doing his regular job? YES ☑ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)* SAC Clin. Micro. Lab

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site
College of Veterinary Medicine
Street or P.O. Box: University Dr.
County: Brazos
City: College Station State: TX Zip Code: 77843

24. Cause of Injury(fall, tool, machine, etc.)* possible exposure to mycobacterium tuberculosis

25. List Witnesses Andrew Owen

26. Return to work date/or expected (m-d-y) - -

27. Did employee die? YES ☐ NO ☑

28. Supervisor's Name Dr. Sara Lawhon

29. Date Reported (m-d-y) 02-05-09

30. Date of Hire (m-d-y) 08-15-85

31. Was employee hired or recruited in Texas? YES ☑ NO ☐

32. Length of Service in Current Position Months 6 Years 23

33. Length of Service in Occupation Months 6 Years 23

34. Employee Payroll Classification Code 8073

35. Occupation of Injured Worker Medical Technologist

36. Rate of Pay at this Job $17.06 Hourly $682.40 Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $1364.80 for 80 Hours or 10 Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form Sherry Haddix-Business Associate III

41. Name of Business Texas A&M Vet. Med. Teach Hosp

42. Business Mailing Address and Telephone Number
Street or P.O. Box: University Dr. Bldg#508
Telephone: (979) 845-9107
City: College Station State: TX Zip Code: 77843

43. Business Location (if different from mailing address)
Number and Street
City State Zip Code

44. Federal Tax Identification Number 74-6000-531

45. Primary North American Industry Classification System Code (6 digit) XXXX

46. Specific NAICS Code (6 digit) XXXX

47. Texas Comptroller Taxpayer No. XXXX

48. Workers' Compensation Insurance Company TAMU-Risk Management & Safety

49. Policy Number Self Insured

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X Sherry Haddix-Bus. Assoc. III Date 2-10-09

DWC FORM-1 (Rev. 10/06) Page 3

DIVISION OF WORKERS' COMPENSATION

entered 2/25/09
AR

209-0291-02 KB

Texas Department of State Health Services
Tuberculosis Contact Screening Form

MAY 5 2009

You have been identified as someone who recently spent time in an enclosed area with a person suspected of having tuberculosis (TB) disease. The information below will help the health-care worker interpret the results of the standard tests for possible infection with TB.

Birth Date _____ Birth Country: USA SS# _____

_____ Race: _____ Ethnicity: Caucasian Sex: F

City/State/Zip: _____

TB Symptom Review: ☐ Fever ☐ Chills ☐ Cough ☐ Productive Cough ☐ Night Sweats
☐ Hemoptysis ☐ Weight Loss (≥10%) ☐ Enlarged cervical lymph nodes
☒ Other: possible exposure

(Persons with symptoms of TB need a complete evaluation with skin test, sputum x 3, chest x-ray, and medical evaluation)

Previous Testing/Treatment: Date and results of previous tuberculin skin test (TST): Don't remember but negative

History of treatment of TB infection or disease: ☐ No ☐ Yes Dates: _____

History of prior exposure to someone with TB disease: ☐ No ☒ Yes Names/Dates: A long time ago

History that may increase chance of prior exposure to someone with TB disease. Please check all that apply:

- ☐ Residence or travel in country where TB is common Place/Dates: _____
- ☐ Resident or employee of correctional facility Place/Dates: _____
- ☐ Resident or employee of homeless shelter Place/Dates: _____
- ☐ Resident or volunteer in disaster shelter Place/Dates: _____
- ☐ Resident of long term care facility Place/Dates: _____
- ☐ Health care worker Place/Dates: _____
- ☐ Injection drug use

RECEIVED
2009 MAY 14 AM 9:40
TAMUS
OFFICE OF RISK MANAGEMENT

Other Medical History:
Certain conditions may result in a false-negative result to the tuberculin skin test (TST). Please check all that apply:

- ☐ HIV infection
- ☐ Receiving corticosteroids, arthritis medications (e.g., Remicaid, Humira or Enbrel) or other immunosuppressive therapy
- ☐ Immunization in the last 6 weeks with a live virus vaccine
- ☐ Illness in the last 6 weeks with rubeola, influenza, mumps, etc. Comment: _____

Persons with a positive result to the tuberculin skin test (TST) should have a chest x-ray to screen for possible TB disease. Children less than 6 years of age should have two views (PA and lateral). Pregnant women can receive a chest x-ray with proper shielding.
Are you pregnant or trying to become pregnant? ☐ Yes ☒ No Comment: _____

(Recent contacts less than 5 years of age need x-rays (PA & lateral) with medical evaluation even if skin test is < 5mm.)

Some conditions increase the chance of developing TB disease if you are infected with TB. Please check all that apply:

- ☐ Diabetes mellitus
- ☐ Age less than 5 years
- ☐ Leukemias/lymphomas
- ☐ Solid organ transplant
- ☐ HIV infection or AIDS
- ☐ Silicosis
- ☐ Cancer of head/neck/lung
- ☐ Prolonged use of drugs such as prednisone, Remicaid, Humira or Enbrel
- ☐ Gastrectomy or jejunoileal bypass
- ☐ Chronic renal failure or on hemodialysis
- ☐ Weight 10% less than ideal body weight

Type of Recent Exposure
- ☐ Exposure during medical procedure
- ☒ Exposure in congregate setting
- ☒ Exposure in household of person with TB disease
- ☐ Other _____

Age
- ☐ Age < 5 years
- ☐ Age 5-15 years
- ☐ Age > 15 years

First Test/Date: 2/9/09 Read: 2/11/09 Reading: 0 mm Manufacturer: SL Lot #: C2907BA

Second Test/Date: 4/27/09 Read: 4/30/09 Reading: 0 mm Manufacturer: _____ Lot #: C2803AA

First Chest x-ray/Date: _____ Results: _____

Second Chest x-ray/Date: _____ Results: _____

Health-Care Provider: _____

Interpreter: _____

TB-208 Tuberculosis Contact Screening Form Rev 12/07

TEXAS Department of State Health Services

Hammond SO -11-012-013
TAMUS 0128

Texas Department of State Health Services
Tuberculosis Contact Screening Form

You have been identified as someone who recently spent time in an enclosed area with a person suspected of having tuberculosis (TB) disease. The information below will help the health-care worker interpret the results of the standard tests for possible infection with TB.

Birth Date: __ - __ - __ Birth Country: USA SS#: _____

Address: _____ Race: _____ Ethnicity: Caucasian Sex: F

City/State/Zip: _____ Telepho _____

TB Symptom Review: ☐ Fever ☐ Chills ☐ Cough ☐ Productive Cough ☐ Night Sweats
☐ Hemoptysis ☐ Weight Loss (≥10%) ☐ Enlarged cervical lymph nodes
☒ Other: possible exposure

(Persons with symptoms of TB need a complete evaluation with skin test, sputum x 3, chest x-ray, and medical evaluation)

Previous Testing/Treatment: Date and results of previous tuberculin skin test (TST): Don't remember but negative

History of treatment of TB infection or disease: ☐ No ☐ Yes Dates: _____

History of prior exposure to someone with TB disease: ☐ No ☒ Yes Names/Dates: A long time ago

History that may increase chance of prior exposure to someone with TB disease. Please check all that apply:

- ☐ Residence or travel in country where TB is common — Place/Dates: _____
- ☐ Resident or employee of correctional facility — Place/Dates: _____
- ☐ Resident or employee of homeless shelter — Place/Dates: _____
- ☐ Resident or volunteer in disaster shelter — Place/Dates: _____
- ☐ Resident of long term care facility — Place/Dates: _____
- ☐ Health care worker — Place/Dates: _____
- ☐ Injection drug use

RECEIVED
2009 FEB 17 PM 1:10
TAMUS OFFICE OF RISK MANAGEMENT

Other Medical History:

Certain conditions may result in a false-negative result to the tuberculin skin test (TST). Please check all that apply:

- ☐ HIV infection
- ☐ Receiving corticosteroids, arthritis medications (e.g., Remicaid, Humira or Enbrel) or other immunosuppressive therapy
- ☐ Immunization in the last 6 weeks with a live virus vaccine
- ☐ Illness in the last 6 weeks with rubeola, influenza, mumps, etc. Comment: _____

Persons with a positive result to the tuberculin skin test (TST) should have a chest x-ray to screen for possible TB disease. Children less than 6 years of age should have two views (PA and lateral). Pregnant women can receive a chest x-ray with proper shielding.
Are you pregnant or trying to become pregnant? ☐ Yes ☒ No Comment: _____

(Recent contacts less than 5 years of age need x-rays (PA & lateral) with medical evaluation even if skin test is < 5mm.)

Some conditions increase the chance of developing TB disease if you are infected with TB. Please check all that apply:

- ☐ Diabetes mellitus
- ☐ Age less than 5 years
- ☐ Leukemias/lymphomas
- ☐ Solid organ transplant
- ☐ HIV infection or AIDS
- ☐ Silicosis
- ☐ Cancer of head/neck/lung
- ☐ Prolonged use of drugs such as prednisone, Remicaid, Humira or Enbrel
- ☐ Gastrectomy or jejunoileal bypass
- ☐ Chronic renal failure or on hemodialysis
- ☐ Weight 10% less than ideal body weight

Type of Recent Exposure

- ☐ Exposure during medical procedure
- ☒ Exposure in congregate setting
- ☒ Exposure in household of person with TB disease
- ☐ Other _____

Age

- ☐ Age < 5 years
- ☐ Age 5-15 years
- ☐ Age > 15 years

First Test/Date: 2/9/09 Read: 2/11/09 Reading: 0 mm Manufacturer: SP Lot #: C0907BA

Second Test/Date: _____ Read: _____ Reading: ____ mm Manufacturer: _____ Lot #: _____

First Chest x-ray/Date: _____ Results: _____

Second Chest x-ray/Date: _____ Results: _____

Health-Care Provider: _____

Interpreter: _____

TEXAS Department of State Health Services

TDH

GENERAL CONSENT AND DISCLOSURE

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services and, if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

NOTIFICATION: _____
(Name of Health Department)
(hereafter called the Department) encourages individuals to seek a personal physician for periodic health examinations and for treatment of health problems. The Department clinic services are targeted primarily toward prevention of health problems among those who cannot access a physician. The Department cannot assume the responsibility for payment of medical care received outside this clinic, including the delivery of babies, unless previous authorization has been given.

DISCLAIMER ON SCREENING: Among its services, the Department utilizes screening tests, which are a method of identifying individuals who are at risk for developing several common medical problems. In this way they can alert you to promptly seek medical evaluation and treatment from a private physician of your choosing. Screening tests perform valuable service in helping to find certain diseases early in their course. However, these screening tests do not cover all diseases, and they may miss some cases of diseases they are intended to find. They are not diagnostic and they do not constitute a complete exam.

GENERAL CONSENT: I give permission to the Department, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests, give injections, medications, and other treatments, and render other health services to the patient identified on this form.

INFORMED CONSENT: In addition to the above general consent, I understand that special informed consent forms must be read and signed for the following procedures: medications for tuberculosis and Hansen's Disease, immunizations, injectable medication for sexually transmitted diseases, family planning methods, PKU special counseling, HIV testing, and certain other things.

PRIVACY NOTICE: I acknowledge that I have received a copy of the Department's HIPAA Privacy Notice.

QUESTIONS: I certify that this form has been fully explained to me, that any blank lines have been filled in and that ar questions I have had about the services have been answered to my satisfaction.

SIGNATURES: Fill blank lines with NA if not applicable.

SECTION I:

Patient's Name___ __Patient's Signature___

Person Authorized to Consent (if not patient)_____Relationship_____

Signature_____Date 2/9/09

SECTION II: I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Patient's Name _____

Name of Person Giving Consent _____Signature_____

Relationship to Patient _____Date_____

Address_____

Phone Number_____

SECTION III:

Counselor Signature _____Date_____

TDH

GENERAL CONSENT AND DISCLOSURE

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services and, if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

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Signature_____Date 2/9/09

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Patient's Name _____

Name of Person Giving Consent _____Signature_____

Relationship to Patient _____Date_____

Address_____

Phone Number_____

SECTION III:

Counselor Signature _____Date_____

TAMUS RECORDS VERIFICATION

INJURED EMPLOYEE [redacted]
SOCIAL SECURITY#

CLAIM NUMBER	DATE OF INJURY	BODY PART	O	C	DISPOSITION
208.0433-02	5/21/08	Trunk' Upper			M$ 219.20
		Back Area -	✓		I$ 0
		(Thoracic Area)			LAE$ 13.50
					M$
					I$
					LAE$
					M$
					I$
					LAE$
					M$
					I$
					LAE$
					M$
					I$
					LAE$
					M$
					I$
					LAE$
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					LAE$
					M$
					I$
					LAE$

WORKERS' COMPENSATION
INITIAL STATUS OF CLAIM REPORT

To:	**Jim Kuhlmann**	Date:	**03/02/09**
	TAMU	RE:	
		Employed By	**TAMU**
		Supervisor:	**Dr. Sara Lawhorn**
		D.O.I.:	**02/02/2009**
		Claim No.:	**209-0291-02**

PLEASE USE THE INFORMATION BELOW AS YOU DEEM NECESSARY

☐ We have received a medical bill/report that indicates an injury may have occurred on . Please verify with your records. If an injury occurred forward a copy of the Employer's First Report of Injury or your incident/accident report so we may timely process the medical bill. If an injury has not been reported, please notify this office, in writing, as soon as possible. ***If a response is not received within 3 days of receipt of this notice the claim for compensability will be accepted.***

☐ The employer's First Report of Injury has been received. Weekly compensation benefits will begin after the seven day waiting period pursuant to the Texas Workers' Compensation Act if disability continues **unless a Supplemental Report of Injury is received indicating the employee has returned to work or unless the Request for Paid Leave is received indicating that the employee will use sick and or annual leave.** A wage statement is required if the employee is disabled for more than eight days, even if the employee is using sick/annual leave of FMLA leave.

☐ This claim has been accepted as a compensable injury.

☐ This is a questionable claim. However, sufficient evidence does not exist at this time to contest compensability. Please provide us with written witness statements, and any other objective information that would assist us in making a determination of compensability.

☒ This claim has been denied because:
- ☒ There was no injury in course and scope of employment
- ☐ The injury was not sustained in the course & scope of employment
- ☐ Untimely notice of injury was given
- ☐ The injury is considered an ordinary disease of life
- ☐ Disability only, medical documentation required to establish physical harm
- ☐ Other:

☐ Other:
Thanks

Please direct any questions regarding this claim and the above information to:

The Texas A&M University System
Office of Risk Management & Safety
College Station, TX 77845-3424
Phone: 979/458-6330 Fax: 979/458-6247

Adjuster: Kaye Ball
F:wci,procedure;office

CHECK LIST FOR NEW FOLDERS

- ☐ Prepare lost time chart
- ☐ Acceptance Letter
- ☐ Contact injured employee for statement by telephone: date-_____
- ☐ Employer initial status of claim (blue sheet)
  - ☐ Wage statement
  - ☐ Request for Paid Leave
  - ☑ Supplemental
  - ☐ Emailed on 3/4/09
- ☐ Initial questionnaire to Claimant
- ☐ Work status tracking log
- ☐ Copy of work status to employer
- ☐ Update work status in Allegro
- ☐ Update claim notes for extent of injury & controverted
- ☑ PLN ☒1 ☐2 ☐6 ☐11
- ☐ EDI 1st report (LWOP not using sick/annual leave) _____
- ☐ DWC Record Check
- ☐ Request witness statement
- ☐ COMP Divider
- ☐ Diary
  - ☐ PLN 11 (defined Extent of Injury within 60 days)
  - ☐ 8th Day of Disability, Elimination Week & Week 26

Subrogated claim:

- ☐ Notice to claimant
- ☐ Notice to 3rd party
- ☐ Notice to 3rd party insurance
- ☐ Request accident report

Work status change:

- ☐ Update lost time in Allegro
- ☐ Update work status tracking log
- ☐ Copy of work status to Employer

Impairment benefits:

- ☐ EDI 1st report
- ☐ PLN 3
- ☐ Update Allegro MMI/IR
- ☐ Subsequent Status Claim form to Employer

Request wage statement?

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Toll Free: 866-249-8574 • Fax 979-458-6247 • http://tamusystem.tamu.edu

NOTICE OF DENIAL OF COMPENSABILITY/LIABILITY AND REFUSAL TO PAY BENEFITS

DATE: March 2, 2009

TO: NAME OF INJURED EMPLOYEE:
ADDRESS:
CITY, STATE, ZIP:

FAXED TO STARR
DATE 3/3/09 AS

RE: DATE OF INJURY: 02/02/2009
NATURE OF INJURY: exposure to tuberculosis
PART OF BODY INJURED: whole body
EMPLOYEE SSN:
DWC #: Unassigned
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 209-0294-02
EMPLOYER NAME: Texas A&M University
EMPLOYER ADDRESS: General Services Complex, Ste. 1201
EMPLOYER CITY, STATE, ZIP: College Station, TX 77843-1255

On February25, 2009 we received notice that you reported an on the job injury. We are denying your claim for workers' compensation benefits. Workers' compensation benefits, including medical benefits, are not being paid because:

The Texas A&M University System as the workers' compensation insurance carrier for the Texas A&M University denies compensability/liability for the exposure to tuberculosis that occurred on or about 02/02/2009. Exposure in and of itself would not be considered an injury in course and scope of employment, absent physical harm or damage to the body nor an occupational disease absent an illness resultant from the exposure. If further evidence is presented, it will be reviewed.

If you do not agree with the denial and refusal to pay benefits, please contact me:

Adjuster's Name: Kaye Ball
Toll Free Telephone #: 1-866-249-8574
Fax #/E-mail Address: 1-979-458-6247/KBall@tamu.edu

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. Contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

Cc: DWC, 7551 Metro Center Drive, Ste. 100, Austin, Texas 78744-1645

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	1181
RECIPIENT ADDRESS	917134624143
DESTINATION ID	
ST. TIME	03/03 17:13
TIME USE	00'28
PAGES SENT	1
RESULT	OK

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Toll Free: 866-249-8574 • Fax 979-458-6247 • http://tamusystem.tamu.edu

NOTICE OF DENIAL OF COMPENSABILITY/LIABILITY AND REFUSAL TO PAY BENEFITS

DATE: March 2, 2009

TO: NAME OF INJURED EMPLOYEE:
ADDRESS:
CITY, STATE, ZIP:

FAXED TO STARR
DATE: 3/3/09 RS

RE: DATE OF INJURY: 02/02/2009
NATURE OF INJURY: exposure to tuberculosis
PART OF BODY INJURED: whole body
EMPLOYEE SSN:
DWC #: Unassigned
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 209-0294-02
EMPLOYER NAME: Texas A&M University
EMPLOYER ADDRESS: General Services Complex, Ste. 1201
EMPLOYER CITY, STATE, ZIP: College Station, TX 77843-1255

On February25, 2009 we received notice that you reported an on the job injury. We are denying your claim for workers' compensation benefits. Workers' compensation benefits, including medical benefits, are not being paid because:

The Texas A&M University System as the workers' compensation insurance carrier for the Texas A&M University denies compensability/liability for the exposure to tuberculosis that occurred on or about 02/02/2009. Exposure in and of itself would not be considered an injury in course and scope of employment, absent physical harm or damage to the body nor an occupational disease absent an illness resultant from the exposure. If further evidence is presented, it will be reviewed.

If you do not agree with the denial and refusal to pay benefits, please contact me:

Adjuster's Name: Kaye Ball
Toll Free Telephone #: 1-866-249-8574
Fax #/E-mail Address: 1-979-458-6247/KBall@tamu.edu

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. Contact the Division office handling your claim at 1-800-252-7031.

02-20-09;22:39 ; 7-8546 ; Rec'd 2/25/09 # 2/8

Amended Copy

02

INITIAL RESERVES
MEDICAL
INDEMNITY
LAE

LOST TIME Y/N ADJUSTER KB ompensation,

INITIAL RESERVES

CLAIM #

CARRIER'S CLAIM # 209-0294-02

EMPLOYERS FIRST REPORT OF INJUBY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☑ M ☐

3. Social Security Number 4. Home Phone 5. Date of Birth (m-d-y)

6. Does the employee speak English? If No, Specify Language
YES ☑ NO ☐

7. Race White ☑ Black ☐ Asian ☐

8. Ethnicity Hispanic ☐ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City

10. Marital Status

11. Number of Dependent Children 12. Spouse's Name

13. Doctor's Name

14. Doctor's Mailing Address (Street or P.O.Box)

City State Zip Code

15. Date of Injury (m-d-y) 11-21-08 10-22-08

16. Time of Injury 2-2-09 am ☐ pm ☐

17. Date Last Time Began (m-d-y) NLT - -

18. Nature of Injury* possible exposure

19. Part of Body Injured or Exposed* bird has mycobacterium tuberculosis

20. How and Why Injury/Illness Occurred* In same room as samples

21. Was employee doing his regular job? YES ☑ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)* SAC Clin. Micro. Lab

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site
College of Veterinary Medicine
Street or P.O. Box University Dr.
County Brazos
City College Station State TX Zip Code 77843

24. Cause of Injury(fall, tool, machine, etc.)* possible exposure to mycobacterium tuberculosis

25. List Witnesses Kay Duncan, Andrew Owen

26. Return to work date/or expected (m-d-y) - -

27. Did employee die? YES ☐ NO ☑

28. Supervisor's Name Dr. Sara Lawhon

29. Date Reported (m-d-y) 02 -05 -09

30. Date of Hire (m-d-y) 11 - 01 - 07

31. Was employee hired or recruited in Texas? YES ☑ NO ☐

32. Length of Service in Current Position Months 3 Years 1

33. Length of Service in Occupation Months 3 Years 1

34. Employee Payroll Classification Code 5076

35. Occupation of Injured Worker ~~Animal Specialist II~~ Technician I

36. Rate of Pay at this Job $12.75 Hourly $510.00 Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $1020.00 for 80 Hours or 10 Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form Sherry Haddix-Business Associate III

41. Name of Business Texas A&M Vet. Med. Teach Hosp

42. Business Mailing Address and Telephone Number
Street or P.O. Box University Dr. Bldg#508
Telephone (979) 845-9107
City College Station State TX Zip Code 77843

43. Business Location (if different from mailing address)
Number and Street
City State Zip Code

44. Federal Tax Identification Number 74-6000-531

45. Primary North American Industry Classification System Code:(6 digit) XXXX

46. Specific NAICS Code (6 digit) XXXX

47. Texas Comptroller Taxpayer No. XXXX

48. Workers' Compensation Insurance Company TAMU-Risk Management & Safety

49. Policy Number Self Insured

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X Sherry Haddix - Business Assoc. III Date 2-10-09

DWC FORM-1 (Rev. 10/06) Page 3

DIVISION OF WORKERS' COMPENSATION

Entered 2/25/09 AS

WORKERS' COMPENSATION
INITIAL STATUS OF CLAIM REPORT

To: **Jim Kuhlmann**	Date: **03/02/09**
TAMU	RE:
	Employed By **TAMU**
	Supervisor: **Dr. Sara Lawhon**
	D.O.I.: **02/02/2009**
	Claim No.: **209-0294-02**

PLEASE USE THE INFORMATION BELOW AS YOU DEEM NECESSARY

☐ We have received a medical bill/report that indicates an injury may have occurred on . Please verify with your records. If an injury occurred forward a copy of the Employer's First Report of Injury or your incident/accident report so we may timely process the medical bill. If an injury has not been reported, please notify this office, in writing, as soon as possible. ***If a response is not received within 3 days of receipt of this notice the claim for compensability will be accepted.***

☐ The employer's First Report of Injury has been received. Weekly compensation benefits will begin after the seven day waiting period pursuant to the Texas Workers' Compensation Act if disability continues **unless a Supplemental Report of Injury is received indicating the employee has returned to work or unless the Request for Paid Leave is received indicating that the employee will use sick and or annual leave.** A wage statement is required if the employee is disabled for more than eight days, even if the employee is using sick/annual leave of FMLA leave.

☐ This claim has been accepted as a compensable injury.

☐ This is a questionable claim. However, sufficient evidence does not exist at this time to contest compensability. Please provide us with written witness statements, and any other objective information that would assist us in making a determination of compensability.

☒ This claim has been denied because:
- ☒ There was no injury in course and scope of employment
- ☐ The injury was not sustained in the course & scope of employment
- ☐ Untimely notice of injury was given
- ☐ The injury is considered an ordinary disease of life
- ☐ Disability only, medical documentation required to establish physical harm
- ☐ Other:

☐ Other:
Thanks

Please direct any questions regarding this claim and the above information to:

The Texas A&M University System
Office of Risk Management & Safety
College Station, TX 77845-3424
Phone: 979/458-6330 Fax: 979/458-6247

Adjuster: Kaye Ball
F:wcl,procedure;office

CHECK LIST FOR NEW FOLDERS

- ☐ Prepare lost time chart
- ☐ Acceptance Letter
- ☐ Contact injured employee for statement by telephone: date-_____
- ☑ Employer initial status of claim (blue sheet)
  - ☐ Wage statement
  - ☐ Request for Paid Leave
  - ☑ Supplemental
  - ☑ Emailed on 3/9/09
- ☐ Initial questionnaire to Claimant
- ☐ Work status tracking log
- ☐ Copy of work status to employer
- ☐ Update work status in Allegro
- ☑ Update claim notes for extent of injury & controverted
- ☑ PLN ☑1 ☐2 ☐6 ☐11
- ☐ EDI 1st report (LWOP not using sick/annual leave) _____
- ☐ DWC Record Check
- ☐ Request witness statement
- ☐ COMP Divider
- ☐ Diary
  - ☐ PLN 11 (defined Extent of Injury within 60 days)
  - ☐ 8th Day of Disability, Elimination Week & Week 26

Subrogated claim:

- ☐ Notice to claimant
- ☐ Notice to 3rd party
- ☐ Notice to 3rd party insurance
- ☐ Request accident report

Work status change:

- ☐ Update lost time in Allegro
- ☐ Update work status tracking log
- ☐ Copy of work status to Employer

Impairment benefits:

- ☐ EDI 1st report
- ☐ PLN 3
- ☐ Update Allegro MMI/IR
- ☐ Subsequent Status Claim form to Employer

Request wage statement?

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Toll Free: 866-249-8574 • Fax 979-458-6247 • http://tamusystem.tamu.edu

NOTICE OF DENIAL OF COMPENSABILITY/LIABILITY AND REFUSAL TO PAY BENEFITS

DATE: March 2, 2009

TO: NAME OF INJURED EMPLOYEE:
ADDRESS:
CITY, STATE, ZIP:

FAXED TO STARR
DATE 3/3/09 AS

RE: DATE OF INJURY: 02/02/2009
NATURE OF INJURY: exposure to tuberculosis
PART OF BODY INJURED: whole body
EMPLOYEE SSN:
DWC #: Unassigned
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 209-0295-06
EMPLOYER NAME: Texas AgriLife Research
EMPLOYER ADDRESS: 3000 Briarcrest Drive, Ste 504
EMPLOYER CITY, STATE, ZIP: Bryan, TX 77802

On February25, 2009 we received notice that you reported an on the job injury. We are denying your claim for workers' compensation benefits. Workers' compensation benefits, including medical benefits, are not being paid because:

The Texas A&M University System as the workers' compensation insurance carrier for the Texas AgriLife Research denies compensability/liability for the exposure to tuberculosis that occurred on or about 02/02/2009. Exposure in and of itself would not be considered an injury in course and scope of employment, absent physical harm or damage to the body nor an occupational disease absent an illness resultant from the exposure. If further evidence is presented, it will be reviewed.

If you do not agree with the denial and refusal to pay benefits, please contact me:

Adjuster's Name: Kaye Ball
Toll Free Telephone #: 1-866-249-8574
Fax #/E-mail Address: 1-979-458-6247/KBall@tamu.edu

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. Contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

Cc: DWC, 7551 Metro Center Drive, Ste. 100, Austin, Texas 78744-1645

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	1182
RECIPIENT ADDRESS	917134624143
DESTINATION ID	
ST. TIME	03/03 17:18
TIME USE	00'30
PAGES SENT	1
RESULT	OK

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Toll Free: 866-249-8574 • Fax 979-458-6247 • http://tamusystem.tamu.edu

NOTICE OF DENIAL OF COMPENSABILITY/LIABILITY AND REFUSAL TO PAY BENEFITS

DATE: March 2, 2009

TO: NAME OF INJURED EMPLOYEE:
ADDRESS:
CITY, STATE, ZIP:

FAXED TO STARR
DATE: 3/3/09 AS

RE: DATE OF INJURY: 02/02/2009
NATURE OF INJURY: exposure to tuberculosis
PART OF BODY INJURED: whole body
EMPLOYEE SSN: 4
DWC #: Unassigned
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 209-0295-06
EMPLOYER NAME: Texas AgriLife Research
EMPLOYER ADDRESS: 3000 Briarcrest Drive, Ste 504
EMPLOYER CITY, STATE, ZIP: Bryan, TX 77802

On February25, 2009 we received notice that you reported an on the job injury. We are denying your claim for workers' compensation benefits. Workers' compensation benefits, including medical benefits, are not being paid because:

The Texas A&M University System as the workers' compensation insurance carrier for the Texas AgriLife Research denies compensability/liability for the exposure to tuberculosis that occurred on or about 02/02/2009. Exposure in and of itself would not be considered an injury in course and scope of employment, absent physical harm or damage to the body nor an occupational disease absent an illness resultant from the exposure. If further evidence is presented, it will be reviewed.

If you do not agree with the denial and refusal to pay benefits, please contact me:

Adjuster's Name: **Kaye Ball**
Toll Free Telephone #: **1-866-249-8574**
Fax #/E-mail Address: **1-979-458-6247/KBall@tamu.edu**

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. Contact the Division office handling your claim at 1-800-252-7031.

02-20-09;22:39 ;

7-8546

Rcvd 2/25/09

Amended Copy

06

Send the specified copies to your
INITIAL RESERVES
MEDICAL _____
INDEMNITY _____
LAE _____

LOST TIME Y/N ADJUSTER KB

ensation,

INITIAL RESERVES

CLAIM # _____

CARRIER'S CLAIM # 209-0295-06

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☑ M ☐

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y)

6. Does the Employee Speak English? If No, Specify Language
YES ☑ NO ☐

7. Race White ☐ Black ☐ Asian ☐

8. Ethnicity Hispanic ☑ Native American ☐ Other ☐

9. Mailing Address ☐ P.O. Box

City State Zip Code

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name

14. Doctor's Mailing Address (Street or P.O.Box)

City State Zip Code

15. Date of Injury (m-d-y) 10 - 22 - 08 2/3/09

16. Time of Injury : am ☐ pm ☐

17. Date Lost Time Began (m-d-y) N.I.T. - -

18. Nature of Injury* possible exposure

19. Part of Body Injured or Exposed* bird has mycobacterium tuberculosis

20. How and Why Injury/Illness Occurred* tissue set up for fungal culture

21. Was employee doing his regular job? YES ☑ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)* SAC Clin. Micro. Lab

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site
College of Veterinary Medicine
Street or P.O. Box University Dr.
County Brazos
City College Station State TX Zip Code 77843

24. Cause of Injury(fall, tool, machine, etc.)* possible exposure to mycobacterium tuberculosis

25. List Witnesses

26. Return to work date/or expected (m-d-y) - -

27. Did employee die? YES ☐ NO ☑

28. Supervisor's Name Dr. Libal

29. Date Reported (m-d-y) 02 -09 -09

30. Date of Hire (m-d-y) 02 - 20 - 92

31. Was employee hired or recruited in Texas? YES ☑ NO ☐

32. Length of Service in Current Position Months ____ Years 17

33. Length of Service in Occupation Months ____ Years 17

34. Employee Payroll Classification Code 9241

35. Occupation of Injured Worker Tech. Lab Coordinator

36. Rate of Pay at this Job $ ____ Hourly $ 3270.58 Monthly Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $ 3270.58 for 160 Hours or 20 Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form
Sherry Haddix-Business Associate III

41. Name of Business
Texas A&M Vet. Med. Teach Hosp

42. Business Mailing Address and Telephone Number
Street or P.O. Box University Dr. Bldg#508
Telephone (979) 845-9107
City College Station State TX Zip Code 77843

43. Business Location (if different from mailing address)
Number and Street
City State Zip Code

44. Federal Tax Identification Number 74-6000-531

45. Primary North American Industry Classification System Code (6 digit) XXXX

46. Specific NAICS Code (6 digit) XXXX

47. Texas Comptroller Taxpayer No. XXXX

48. Workers' Compensation Insurance Company
TAMU-Risk Management & Safety

49. Policy Number
Self Insured

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

51. Signature of and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X Sherry Haddix-Bus. Assoc. III Date 2-10-09

DWC FORM-1 (Rev. 10/05) Page 3

DIVISION OF WORKERS' COMPENSATION

entered 2/25/09 AR

209-0295-06 KB

Texas Department of State Health Servi
Tuberculosis Contact Screening Form

MAY 5 2009

You have been identified as someone who recently spent time in an enclosed area with a person suspected of having tuberculosis (TB) disease. The information below will help the health-care worker interpret the results of the standard tests for pos·ible ·nfection with TB.

Name:_ _ _ Birth Da Birth Country: USA SS#: _____

Address:___ ___ _ _____ Race: white Ethnicity: Hispanic Sex: F

City, State, Zip:_____ Telephone:_____

TB Symptom Review: ☐ Fever ☐ Chills ☐ Cough ☐ Productive Cough ☐ Night Sweats
☐ Hemoptysis ☐ Weight Loss (≥10%) ☐ Enlarged cervical lymph nodes
☐ Other: _____

(Persons with symptoms of TB need a complete evaluation with skin test, sputum x 3, chest x-ray, and medical evaluation)

Previous Testing/Treatment: Date and results of previous tuberculin skin test (TST): _____

History of treatment of TB infection or disease: ☒ No ☐ Yes Dates:_____

History of prior exposure to someone with TB disease: ☒ No ☐ Yes Names/Dates:_____

History that may increase chance of prior exposure to someone with TB disease. Please check all that apply:

☐ Residence or travel in country where TB is common Place/Dates:_____
☐ Resident or employee of correctional facility Place/Dates:_____
☐ Resident or employee of homeless shelter Place/Dates:_____
☐ Resident or volunteer in disaster shelter Place/Dates:_____
☐ Resident of long term care facility Place/Dates:_____
☐ Health care worker Place/Dates:_____
☐ Injection drug use

RECEIVED
2009 MAY 14 AM 9:0
TAMUS
OFFICE OF
RISK MANAGEMENT

Other Medical History:
Certain conditions may result in a false-negative result to the tuberculin skin test (TST). Please check all that apply:
☐ HIV infection
☐ Receiving corticosteroids, arthritis medications (e.g., Remicaid, Humira or Enbrel) or other immunosuppressive therapy
☐ Immunization in the last 6 weeks with a live virus vaccine
☐ Illness in the last 6 weeks with rubeola, influenza, mumps, etc. Comment:_____

Persons with a positive result to the tuberculin skin test (TST) should have a chest x-ray to screen for possible TB disease. Children less than 6 years of age should have two views (PA and lateral). Pregnant women can receive a chest x-ray with proper shielding.
Are you pregnant or trying to become pregnant? ☐ Yes ☒ No Comment:_____

(Recent contacts less than 5 years of age need x-rays (PA & lateral) with medical evaluation even if skin test is < 5mm.)

Some conditions increase the chance of developing TB disease if you are infected with TB. Please check all that apply:

☐ Diabetes mellitus
☐ Age less than 5 years
☐ Leukemias/lymphomas
☐ Solid organ transplant
☐ HIV infection or AIDS
☐ Silicosis
☐ Cancer of head/neck/lung
☐ Prolonged use of drugs such as prednisone, Remicaid, Humira or Enbrel
☐ Gastrectomy or jejunoileal bypass
☐ Chronic renal failure or on hemodialysis
☐ Weight 10% less than ideal body weight

Type of Recent Exposure
☐ Exposure during medical procedure
☐ Exposure in congregate setting
☐ Exposure in household of person with TB disease
☒ Other Setting up culture for in MICRO Lab

Age
☐ Age < 5 years
☐ Age 5-15 years
☒ Age > 15 years

First Test/Date: 2/9/09 Read: 2/11/09 Reading: 0 mm Manufacturer:_____ Lot #: C2907BA
Second Test/Date: 4/27/09 Read: 4/30/09 Reading: 0 mm Manufacturer: Sanofi Past. Lot #: C2803AA
First Chest x-ray/Date:_____ Results:_____
Second Chest x-ray/Date:_____ Results:_____
Health-Care Provider: _____
Interpreter:_____

TEXAS Department of State Health Services

Texas Department of State Health Services
Tuberculosis Contact Screening Form

You have been identified as someone who recently spent time in an enclosed area with a person suspected of having tuberculosis (TB) disease. The information below will help the health-care worker interpret the results of the standard tests for possible infection with TB.

Name: _____ Birth Date: _____ Country: USA SS#: _____

Address: P.O. BOX 51 Race: white Ethnicity: Hispanic Sex: F

City/State/Zip: _____ Telephone: _____

TB Symptom Review: ☐ Fever ☐ Chills ☐ Cough ☐ Productive Cough ☐ Night Sweats
☐ Hemoptysis ☐ Weight Loss (≥10%) ☐ Enlarged cervical lymph nodes
☐ Other: _____

(Persons with symptoms of TB need a complete evaluation with skin test, sputum x 3, chest x-ray, and medical evaluation)

Previous Testing/Treatment: Date and results of previous tuberculin skin test (TST): _____

History of treatment of TB infection or disease: ☒ No ☐ Yes Dates: _____

History of prior exposure to someone with TB disease: ☒ No ☐ Yes Names/Dates: _____

History that may increase chance of prior exposure to someone with TB disease. Please check all that apply:

☐ Residence or travel in country where TB is common Place/Dates: _____
☐ Resident or employee of correctional facility Place/Dates: _____
☐ Resident or employee of homeless shelter Place/Dates: _____
☐ Resident or volunteer in disaster shelter Place/Dates: _____
☐ Resident of long term care facility Place/Dates: _____
☐ Health care worker Place/Dates: _____
☐ Injection drug use

RECEIVED
2009 FEB 17 P 1:10
TAMUS
OFFICE OF RISK MANAGEMENT

Other Medical History:
Certain conditions may result in a false-negative result to the tuberculin skin test (TST). Please check all that apply:
☐ HIV infection
☐ Receiving corticosteroids, arthritis medications (e.g., Remicaid, Humira or Enbrel) or other immunosuppressive therapy
☐ Immunization in the last 6 weeks with a live virus vaccine
☐ Illness in the last 6 weeks with rubeola, influenza, mumps, etc. Comment: _____

Persons with a positive result to the tuberculin skin test (TST) should have a chest x-ray to screen for possible TB disease. Children less than 6 years of age should have two views (PA and lateral). Pregnant women can receive a chest x-ray with proper shielding.
Are you pregnant or trying to become pregnant? ☐ Yes ☒ No Comment: _____

(Recent contacts less than 5 years of age need x-rays (PA & lateral) with medical evaluation even if skin test is < 5mm.)

Some conditions increase the chance of developing TB disease if you are infected with TB. Please check all that apply:

☐ Diabetes mellitus ☐ HIV infection or AIDS ☐ Gastrectomy or jejunoileal bypass
☐ Age less than 5 years ☐ Silicosis ☐ Chronic renal failure or on hemodialysis
☐ Leukemias/lymphomas ☐ Cancer of head/neck/lung ☐ Weight 10% less than ideal body weight
☐ Solid organ transplant ☐ Prolonged use of drugs such as prednisone, Remicaid, Humira or Enbrel

Type of Recent Exposure
☐ Exposure during medical procedure
☐ Exposure in congregate setting
☐ Exposure in household of person with TB disease
☒ Other Setting up culture for in Micro Lab

Age
☐ Age < 5 years
☐ Age 5-15 years
☒ Age > 15 years

First Test/Date: 2/9/09 Read: 2/11/09 Reading: 0 mm Manufacturer: _____ Lot #: C2907BA

Second Test/Date: _____ Read: _____ Reading: ____ mm Manufacturer: _____ Lot #: _____

First Chest x-ray/Date: _____ Results: _____

Second Chest x-ray/Date: _____ Results: _____

Health-Care Provider: _____

Interpreter: _____

TEXAS Department of State Health Services

TDH

GENERAL CONSENT AND DISCLOSURE

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services and, if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

NOTIFICATION: _____
(Name of Health Department)
(hereafter called the Department) encourages individuals to seek a personal physician for periodic health examinations and for treatment of health problems. The Department clinic services are targeted primarily toward prevention of health problems among those who cannot access a physician. The Department cannot assume the responsibility for payment of medical care received outside this clinic, including the delivery of babies, unless previous authorization has been given.

DISCLAIMER ON SCREENING: Among its services, the Department utilizes screening tests, which are a method of identifying individuals who are at risk for developing several common medical problems. In this way they can alert you to promptly seek medical evaluation and treatment from a private physician of your choosing. Screening tests perform valuable service in helping to find certain diseases early in their course. However, these screening tests do not cover all diseases, and they may miss some cases of diseases they are intended to find. They are not diagnostic and they do not constitute a complete exam.

GENERAL CONSENT: I give permission to the Department, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests, give injections, medications, and other treatments, and render other health services to the patient identified on this form.

INFORMED CONSENT: In addition to the above general consent, I understand that special informed consent forms must be read and signed for the following procedures: medications for tuberculosis and Hansen's Disease, immunizations, injectable medication for sexually transmitted diseases, family planning methods, PKU special counseling, HIV testing, and certain other things.

PRIVACY NOTICE: I acknowledge that I have received a copy of the Department's HIPAA Privacy Notice.

QUESTIONS: I certify that this form has been fully explained to me, that any blank lines have been filled in and that ar questions I have had about the services have been answered to my satisfaction.

SIGNATURES: Fill blank lines with NA if not applicable.

SECTION I:

Patient's Name_____ Patient's Signature_____

Person Authorized to Consent (if not patient)_____ Relationship_____

Signature_____ Date_____

SECTION II: I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Patient's Name _____

Name of Person Giving Consent _____ Signature_____

Relationship to Patient _____ Date_____

Address_____

Phone Number_____

SECTION III:

Counselor Signature _____ Date_____

TAMUS RECORDS VERIFICATION

Date: 2/12/04

INJURED EMPLOYEE _____

SOCIAL SECURITY# _____

CLAIM NUMBER	DATE OF INJURY	BODY PART	O	C	DISPOSITION
202-0436-02	1/12/02	Multiple; Body Systems & Multiple Body Systems		✓	M$ 0 I$ 0 LAE$ 0
202-0555-02	2/22/02	Upper Ext; Finger(s)		✓	M$ 0 I$ 0 LAE$ 0
					M$ I$ LAE$
					M$ I$ LAE$
					M$ I$ LAE$
					M$ I$ LAE$
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					M$ I$ LAE$
					M$ I$ LAE$

AFFIDAVIT

STATE OF TEXAS

COUNTY OF Brazos

KNOW ALL YE MEN BY THESE PRESENTS,

That on this 19 day of February, 2009, personally came and __, of Clinical Microbiology Lab, known, and known to me, who after being first duly sworn, deposes and says:

On Sept 30, 2009 I set up a fungal culture from an eye swab submitted to the Clinical Microbiology Lab. The sample was handled under a Biological Safety Cabinet. I cannot recall any other person being present in the room.

FURTHER AFFIANT SAYETH NOT

SUBSCRIBED TO AND SWORN TO before me this 19 day of February, 19, 2009.

Debra Lynne Anderson
NOTARY PUBLIC

My Commission Expires 4/24/2010

DEBRA LYNNE ANDERSON
MY COMMISSION EXPIRES
April 24, 2010

RECEIVED
2009 FEB 24 AM 9:44
TAMUS
OFFICE OF RISK MANAGEMENT

AFFIDAVIT

STATE OF TEXAS

COUNTY OF Brazos

KNOW ALL YE MEN BY THESE PRESENTS,

That on this 19 day of October, 2009, personally came and appeared, of Clinical Microbiology Lab, known, and known to me, who after being first duly sworn, deposes and says:

On Sept 30, 2009 I set up a fungal culture from an eye swab submitted to the Clinical Microbiology Lab. The sample was handled under a Biological Safety Cabinet. I cannot recall any other person being present in the room.

FURTHER AFFIANT SAYETH NOT.

SUBSCRIBED TO AND SWORN TO before me this 19 day of January, 19, 2009.

Debra Lynne Anderson
NOTARY PUBLIC

My Commission Expires 4/24/2010

DEBRA LYNNE ANDERSON
MY COMMISSION EXPIRES
April 24, 2010

WORKERS' COMPENSATION
INITIAL STATUS OF CLAIM REPORT

To:	**Bob Hensz**	Date:	**03/02/2009**
	Texas AgriLife Research	RE:	
		Employed By	**AgriLife Research**
		Supervisor:	**Dr. Libal**
		D.O.I.:	**02/02/09**
		Claim No.:	**209-0295-06**

PLEASE USE THE INFORMATION BELOW AS YOU DEEM NECESSARY

☐ We have received a medical bill/report that indicates an injury may have occurred on . Please verify with your records. If an injury occurred forward a copy of the Employer's First Report of Injury or your incident/accident report so we may timely process the medical bill. If an injury has not been reported, please notify this office, in writing, as soon as possible. ***If a response is not received within 3 days of receipt of this notice the claim for compensability will be accepted.***

☐ The employer's First Report of Injury has been received. Weekly compensation benefits will begin after the seven day waiting period pursuant to the Texas Workers' Compensation Act if disability continues **unless a Supplemental Report of Injury is received indicating the employee has returned to work or unless the Request for Paid Leave is received indicating that the employee will use sick and or annual leave.** A wage statement is required if the employee is disabled for more than eight days, even if the employee is using sick/annual leave of FMLA leave.

☐ This claim has been accepted as a compensable injury.

☐ This is a questionable claim. However, sufficient evidence does not exist at this time to contest compensability. Please provide us with written witness statements, and any other objective information that would assist us in making a determination of compensability.

☒ This claim has been denied because:
- ☒ There was no injury in course and scope of employment
- ☐ The injury was not sustained in the course & scope of employment
- ☐ Untimely notice of injury was given
- ☐ The injury is considered an ordinary disease of life
- ☐ Disability only, medical documentation required to establish physical harm
- ☐ Other:

☐ Other:
Thanks.

Please direct any questions regarding this claim and the above information to:

The Texas A&M University System
Office of Risk Management & Safety
College Station, TX 77845-3424
Phone: 979/458-6330 Fax: 979/458-6247

Adjuster: Kaye Ball
F:wci,procedure;office

CHECK LIST FOR NEW FOLDERS

CLAIM# 205-0269-02
SS# 432-55-2282

- ☐ Prepare lost time chart
- ☐ Acceptance Letter
- ☐ Contact injured employee for statement by telephone
- ☑ Employer initial status of claim (blue sheet)
  - ☐ Wage statement
  - ☐ Request for Paid Leave
  - ☐ Supplemental
- ☐ Initial questionnaire to Claimant
- ☐ Work status tracking log
- ☐ Copy of work status to employer
- ☐ Update work status in Allegro
- ☑ Update claim notes for extent of injury, controverted & TRPL
- ☑ PLN 1, PLN 2PLN 4, PLN 11 Denial
- ☐ EDI 1st report
- ☐ DWC Record Check
- ☐ Request witness statement

Subrogated claim:

- ☐ Notice to claimant
- ☐ Notice to 3rd party
- ☐ Notice to 3rd party insurance
- ☐ Request accident report

Work status change:

- ☐ Update lost time in Allegro
- ☐ Update work status tracking log
- ☐ Copy of work status to Employer

Impairment benefits:

- ☐ PLN 3
- ☐ EDI 1st report
- ☐ DWC-28
- ☐ Data update to:
  - show date of MMI & impairment rating
  - date disability began (date of MMI if no lost time) to EDI 1st report
    - *Last Status Change:* _____*(date of MMI)*
    - *Disability Status:* _____
    - *Date Disability Began:* _____ *(date of MMI)*
    - *Work Status:* _____
    - *Last Date Employee Worked/Return to Work Date:* *Leave blank*
- ☐ Update notepad (TRPL)
- ☐ Subsequent Status Claim form to Employer
  - Request wage statement?

The Texas A&M University System

Office of the Treasurer
Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Toll Free: 866-249-8574 • Fax 979-458-6247 • http://tamusystem.tamu.edu

NOTICE OF DENIAL OF COMPENSABILITY/LIABILITY AND REFUSAL TO PAY BENEFITS

DATE: March 2, 2009

TO: NAME OF INJURED EMPLOYEE:
ADDRESS:
CITY, STATE, ZIP:

FAXED TO STARR
DATE: 3/3/09 AS

RE: DATE OF INJURY: 02/02/2009
NATURE OF INJURY: exposure to tuberculosis
PART OF BODY INJURED: whole body
EMPLOYEE SSN:
DWC #: Unassigned
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 209-0269-02
EMPLOYER NAME: Texas A&M University Employee Services
EMPLOYER ADDRESS: General Service Complex Ste 1201
EMPLOYER CITY, STATE, ZIP: College Station TX 77843-1255

On 02/25/2009 we received notice that you reported an on the job injury. We are denying your claim for workers' compensation benefits. Workers' compensation benefits, including medical benefits, are not being paid because:

The Texas A&M University System as the workers' compensation insurance carrier for Texas A&M University denies compensability and/or liability for the exposure to tuberculosis on or about 02/02/2009. Exposure in and of itself would not be an injury in course and scope of employment absent physical harm or damage to the body nor an occupational disease absent an illness resultant from the exposure. If further evidence is presented our decision may be reviewed.

If you do not agree with the denial and refusal to pay benefits, please contact me:

Adjuster's Name: Pam Shannon
Toll Free Telephone #: 1-866-249-8574
Fax #/E-mail Address: 1-979-458-6247/Pam@tamu.edu

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference, contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

Cc: DWC, 7551 Metro Center Drive, Ste. 100, Austin, Texas 78744-1645

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	1183
RECIPIENT ADDRESS	817134624143
DESTINATION ID	
ST. TIME	03/03 17:08
TIME USE	00'30
PAGES SENT	1
RESULT	OK

The Texas A&M University System

Office of the Treasurer

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NOTICE OF DENIAL OF COMPENSABILITY/LIABILITY AND REFUSAL TO PAY BENEFITS

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TO: NAME OF INJURED EMPLOYEE:
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FAXED TO STARR
DATE: 3/3/09 AS

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NATURE OF INJURY: exposure to tuberculosis
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DWC #: Unassigned
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 209-0269-02
EMPLOYER NAME: Texas A&M University Employee Services
EMPLOYER ADDRESS: General Service Complex Ste 1201
EMPLOYER CITY, STATE, ZIP: College Station TX 77843-1255

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If you do not agree with the denial and refusal to pay benefits, please contact me:

Adjuster's Name: Pam Shannon
Toll Free Telephone #: 1-866-249-8574
Fax #/E-mail Address: 1-979-458-6247/Pam@tamu.edu

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference, contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile

02-20-09;22:39 ;

7-8546

Rec'd 2/25/09

Amended Copy

INITIAL RESERVES
MEDICAL
INDEMNITY
LAE

LOST TIME Y/N ADJUSTER KB

mpensation,

INITIAL RESERVES

CLAIM #

CARRIER'S CLAIM # 209-0296-02

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☐ M ☑

3. Social Security Number / 4. Home Phone / 5. Date of Birth (m-d-y)

6. Does the Employee Speak English? If No, Specify Language
YES ☑ NO ☐

7. Race White ☑ Black ☐ Asian ☐

8. Ethnicity Hispanic ☐ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City / State / Zip Code

12.

13. Doctor's Name

14. Doctor's Mailing Address (Street or P.O.Box)

City / State / Zip Code

15. Date of Injury (m-d-y) 11-21-08 10-21-08
16. Time of Injury 2:09 am ☐ pm ☐
17. Date Last Time Began (m-d-y) NLT

18. Nature of Injury* possible exposure
19. Part of Body Injured or Exposed* bird has mycobacterium tuberculosis

20. How and Why Injury/Illness Occurred*
in same room as specimens, handled lab specimens, culture plates, broth media etc.

21. Was employee doing his regular job? YES ☑ NO ☐
22. Worksite Location of Injury (state, dock, etc.)* SAC Clin. Micro Lab

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site
College of Veterinary Medicine
Street or P.O. Box: University Dr.
County: Brazos
City: College Station
State: TX
Zip Code: 77843

24. Cause of Injury(fall, tool, machine, etc.)* possible exposure to mycobacterium tuberculosis

25. List Witnesses
Kay Duncan

26. Return to work date/or expected (m-d-y)
27. Did employee die? YES ☐ NO ☑
28. Supervisor's Name: Dr. Sara Lawhon
29. Date Reported (m-d-y): 02-05-09

30. Date of Hire (m-d-y): 01-07-08
31. Was employee hired or recruited in Texas? YES ☑ NO ☐
32. Length of Service in Current Position: Months 1 Years 1
33. Length of Service in Occupation: Months 1 Years 1

34. Employee Payroll Classification Code: 5005
35. Occupation of Injured Worker: Technician I

36. Rate of Pay at this Job: $13.16 Hourly $527.20 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $1054.40 for 80 Hours or 10 Days
39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form: Sherry Haddix-Business Associate III
41. Name of Business: Texas A&M Vet. Med. Teach Hosp
42. Business Mailing Address and Telephone Number
Street or P.O. Box: University Dr. Bldg#608
Telephone: (979) 845-9107
City: College Station
State: TX
Zip Code: 77843
43. Business Location (if different from mailing address)
Number and Street
City / State / Zip Code
44. Federal Tax Identification Number: 74-6000-531
45. Primary North American Industry Classification System Code:(6 digit) XXXX
46. Specific NAICS Code (4 digit) XXXX
47. Texas Comptroller Taxpayer No. XXXX
48. Workers' Compensation Insurance Company: TAMU-Risk Management & Safety
49. Policy Number: Self Insured
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X Sherry Haddix - Bus Assoc. III Date 2-20-09

DWC FORM-1 (Rev. 10/05) Page 3

DIVISION OF WORKERS' COMPENSATION

entered 2/26/09

Clin Micro

209-0296-02 KR

MAY 5 2009

Texas Department of State Health Services
Tuberculosis Contact Screening Form

You have been identified as someone who recently spent time in an enclosed area with a person suspected of having tuberculosis (TB) disease. The information below will help the health-care worker interpret the results of the standard tests for possible infection with TB.

Name:_____ Birth Date:_____ Birth Country: United States SS#_____

Race: ~~Caucasian~~ White Ethnicity: Caucasian Sex: M

City/State/Zip:_____ Telephone:_____

TB Symptom Review: ☐ Fever ☐ Chills ☐ Cough ☐ Productive Cough ☐ Night Sweats
☐ Hemoptysis ☐ Weight Loss (≥10%) ☐ Enlarged cervical lymph nodes
☐ Other:_____

(Persons with symptoms of TB need a complete evaluation with skin test, sputum x 3, chest x-ray, and medical evaluation)

Previous Testing/Treatment: Date and results of previous tuberculin skin test (TST): June 2005 - negative

History of treatment of TB infection or disease: ☒ No ☐ Yes Dates:_____

History of prior exposure to someone with TB disease: ☒ No ☐ Yes Names/Dates:_____

History that may increase chance of prior exposure to someone with TB disease. Please check all that apply:

☐ Residence or travel in country where TB is common Place/Dates:_____
☐ Resident or employee of correctional facility Place/Dates:_____
☐ Resident or employee of homeless shelter Place/Dates:_____
☐ Resident or volunteer in disaster shelter Place/Dates:_____
☐ Resident of long term care facility Place/Dates:_____
☐ Health care worker Place/Dates:_____
☐ Injection drug use

RECEIVED
2009 MAY 14 AM 9:44
TAMUS
OFFICE OF RISK MANAGEMENT

Other Medical History:
Certain conditions may result in a false-negative result to the tuberculin skin test (TST). Please check all that apply:
☐ HIV infection
☐ Receiving corticosteroids, arthritis medications (e.g., Remicaid, Humira or Enbrel) or other immunosuppressive therapy
☐ Immunization in the last 6 weeks with a live virus vaccine
☐ Illness in the last 6 weeks with rubeola, influenza, mumps, etc. Comment:_____

Persons with a positive result to the tuberculin skin test (TST) should have a chest x-ray to screen for possible TB disease. Children less than 6 years of age should have two views (PA and lateral). Pregnant women can receive a chest x-ray with proper shielding.
Are you pregnant or trying to become pregnant? ☐ Yes ☒ No Comment:_____

(Recent contacts less than 5 years of age need x-rays (PA & lateral) with medical evaluation even if skin test is < 5mm.)

Some conditions increase the chance of developing TB disease if you are infected with TB. Please check all that apply:

☐ Diabetes mellitus ☐ HIV infection or AIDS ☐ Gastrectomy or jejunoileal bypass
☐ Age less than 5 years ☐ Silicosis ☐ Chronic renal failure or on hemodialysis
☐ Leukemias/lymphomas ☐ Cancer of head/neck/lung ☐ Weight 10% less than ideal body weight
☐ Solid organ transplant ☐ Prolonged use of drugs such as prednisone, Remicaid, Humira or Enbrel

Type of Recent Exposure
☐ Exposure during medical procedure
☐ Exposure in congregate setting
☐ Exposure in household of person with TB disease
☐ Other _____

Age
☐ Age < 5 years
☐ Age 5-15 years
☒ Age > 15 years

First Test/Date: 2/9/09 Read: 2/11/09 Reading: 0 mm Manufacturer: Sanofi Past. Lot #: C090704A
Second Test/Date: 4/27/09 Read: 4/30/09 Reading: 0 mm Manufacturer: Sanofi Past. Lot #: C2803AA

First Chest x-ray/Date:_____ Results:_____
Second Chest x-ray/Date:_____ Results:_____

Health-Care Provider: Kristin Mann

Interpreter:_____

TEXAS Department of State Health Services

Clin Micro

Texas Department of State Health Services
Tuberculosis Contact Screening Form

You have been identified as someone who recently spent time in an enclosed area with a person suspected of having tuberculosis (TB) disease. The information below will help the health-care worker interpret the results of the standard tests for possible infection with TB.

Name: _____ Birth Date: _____ Birth Country: United States SS#: _____

Address: _____ Race: ~~Caucasian~~ White Ethnicity: Caucasian Sex: M

City/State/Zip: _____ Telephone: _____

TB Symptom Review: ☐ Fever ☐ Chills ☐ Cough ☐ Productive Cough ☐ Night Sweats
☐ Hemoptysis ☐ Weight Loss (≥10%) ☐ Enlarged cervical lymph nodes
☐ Other: _____

(Persons with symptoms of TB need a complete evaluation with skin test, sputum x 3, chest x-ray, and medical evaluation)

Previous Testing/Treatment: Date and results of previous tuberculin skin test (TST): June 2005 - negative

History of treatment of TB infection or disease: ☒ No ☐ Yes Dates: _____

History of prior exposure to someone with TB disease: ☒ No ☐ Yes Names/Dates: _____

History that may increase chance of prior exposure to someone with TB disease. Please check all that apply:

- ☐ Residence or travel in country where TB is common Place/Dates: _____
- ☐ Resident or employee of correctional facility Place/Dates: _____
- ☐ Resident or employee of homeless shelter Place/Dates: _____
- ☐ Resident or volunteer in disaster shelter Place/Dates: _____
- ☐ Resident of long term care facility Place/Dates: _____
- ☐ Health care worker Place/Dates: _____
- ☐ Injection drug use

RECEIVED
2009 FEB 17 PM 1:10
OFFICE OF TAMUS RISK MANAGEMENT

Other Medical History:

Certain conditions may result in a false-negative result to the tuberculin skin test (TST). Please check all that apply:

- ☐ HIV infection
- ☐ Receiving corticosteroids, arthritis medications (e.g., Remicaid, Humira or Enbrel) or other immunosuppressive therapy
- ☐ Immunization in the last 6 weeks with a live virus vaccine
- ☐ Illness in the last 6 weeks with rubeola, influenza, mumps, etc. Comment: _____

Persons with a positive result to the tuberculin skin test (TST) should have a chest x-ray to screen for possible TB disease. Children less than 6 years of age should have two views (PA and lateral). Pregnant women can receive a chest x-ray with proper shielding.
Are you pregnant or trying to become pregnant? ☐ Yes ☒ No Comment: _____

(Recent contacts less than 5 years of age need x-rays (PA & lateral) with medical evaluation even if skin test is < 5mm.)

Some conditions increase the chance of developing TB disease if you are infected with TB. Please check all that apply:

- ☐ Diabetes mellitus
- ☐ Age less than 5 years
- ☐ Leukemias/lymphomas
- ☐ Solid organ transplant
- ☐ HIV infection or AIDS
- ☐ Silicosis
- ☐ Cancer of head/neck/lung
- ☐ Prolonged use of drugs such as prednisone, Remicaid, Humira or Enbrel
- ☐ Gastrectomy or jejunoileal bypass
- ☐ Chronic renal failure or on hemodialysis
- ☐ Weight 10% less than ideal body weight

Type of Recent Exposure
- ☐ Exposure during medical procedure
- ☐ Exposure in congregate setting
- ☐ Exposure in household of person with TB disease
- ☐ Other _____

Age
- ☐ Age < 5 years
- ☐ Age 5-15 years
- ☒ Age > 15 years

First Test/Date: 2/9/09 Read: 2/11/09 Reading: 0 mm Manufacturer: SanofiPast. Lot #: C0980701

Second Test/Date: _____ Read: _____ Reading: ____ mm Manufacturer: _____ Lot #: _____

First Chest x-ray/Date: _____ Results: _____

Second Chest x-ray/Date: _____ Results: _____

Health-Care Provider: _____

Interpreter: _____

TEXAS Department of State Health Services

TDH

GENERAL CONSENT AND DISCLOSURE

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services and, if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

NOTIFICATION: _____
(Name of Health Department)
(hereafter called the Department) encourages individuals to seek a personal physician for periodic health examinations and for treatment of health problems. The Department clinic services are targeted primarily toward prevention of health problems among those who cannot access a physician. The Department cannot assume the responsibility for payment of medical care received outside this clinic, including the delivery of babies, unless previous authorization has been given.

DISCLAIMER ON SCREENING: Among its services, the Department utilizes screening tests, which are a method of identifying individuals who are at risk for developing several common medical problems. In this way they can alert you to promptly seek medical evaluation and treatment from a private physician of your choosing. Screening tests perform valuable service in helping to find certain diseases early in their course. However, these screening tests do not cover all diseases, and they may miss some cases of diseases they are intended to find. They are not diagnostic and they do not constitute a complete exam.

GENERAL CONSENT: I give permission to the Department, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests, give injections, medications, and other treatments, and render other health services to the patient identified on this form.

INFORMED CONSENT: In addition to the above general consent, I understand that special informed consent forms must be read and signed for the following procedures: medications for tuberculosis and Hansen's Disease, immunizations, injectable medication for sexually transmitted diseases, family planning methods, PKU special counseling, HIV testing, and certain other things.

PRIVACY NOTICE: I acknowledge that I have received a copy of the Department's HIPAA Privacy Notice.

QUESTIONS: I certify that this form has been fully explained to me, that any blank lines have been filled in and that ar questions I have had about the services have been answered to my satisfaction.

SIGNATURES: Fill blank lines with NA if not applicable.

SECTION I:

Patient's Name__ _____Patient's Signatu

Person Authorized to Consent (if not patient)_____Relationship_____

Signature_____Date 2/9/09

SECTION II: I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Patient's Name _____

Name of Person Giving Consent _____Signature_____

Relationship to Patient _____Date_____

Address_____

Phone Number_____

SECTION III:

Counselor Signature _____Date_____

WORKERS' COMPENSATION
INITIAL STATUS OF CLAIM REPORT

To:	**Jim Kuhlmann**	Date:	**03/02/09**
	TAMU	RE:	
		Employed By	**TAMU**
		Supervisor:	**Dr. Sara Lawhon**
		D.O.I.:	**02/02/2009**
		Claim No.:	**209-0296-02**

PLEASE USE THE INFORMATION BELOW AS YOU DEEM NECESSARY

☐ We have received a medical bill/report that indicates an injury may have occurred on . Please verify with your records. If an injury occurred forward a copy of the Employer's First Report of Injury or your incident/accident report so we may timely process the medical bill. If an injury has not been reported, please notify this office, in writing, as soon as possible. ***If a response is not received within 3 days of receipt of this notice the claim for compensability will be accepted.***

☐ The employer's First Report of Injury has been received. Weekly compensation benefits will begin after the seven day waiting period pursuant to the Texas Workers' Compensation Act if disability continues **unless a Supplemental Report of Injury is received indicating the employee has returned to work or unless the Request for Paid Leave is received indicating that the employee will use sick and or annual leave.** A wage statement is required if the employee is disabled for more than eight days, even if the employee is using sick/annual leave of FMLA leave.

☐ This claim has been accepted as a compensable injury.

☐ This is a questionable claim. However, sufficient evidence does not exist at this time to contest compensability. Please provide us with written witness statements, and any other objective information that would assist us in making a determination of compensability.

☒ This claim has been denied because:
- ☒ There was no injury in course and scope of employment
- ☐ The injury was not sustained in the course & scope of employment
- ☐ Untimely notice of injury was given
- ☐ The injury is considered an ordinary disease of life
- ☐ Disability only, medical documentation required to establish physical harm
- ☐ Other:

☐ Other:
Thanks

Please direct any questions regarding this claim and the above information to:

The Texas A&M University System
Office of Risk Management & Safety
College Station, TX 77845-3424
Phone: 979/458-6330 Fax: 979/458-6247

Adjuster: Kaye Ball
F:wci,procedure;office

CHECK LIST FOR NEW FOLDERS

- ☐ Prepare lost time chart
- ☑ Acceptance Letter
- ☑ Contact injured employee for statement by telephone: date 06/24/08
- ☑ Employer initial status of claim (blue sheet)
  - ☐ Wage statement
  - ☐ Request for Paid Leave
  - ☐ Supplemental
  - ☑ Emailed on 06/24/08
- ☑ Initial questionnaire to Claimant
- ☐ Work status tracking log
- ☐ Copy of work status to employer
- ☐ Update work status in Allegro
- ☑ Update claim notes for extent of injury & controverted
- ☐ PLN ☐1 ☐2 ☐6 ☐11
- ☐ EDI 1st report (LWOP not using sick/annual leave) _____
- ☐ DWC Record Check
- ☐ Request witness statement
- ☐ COMP Divider
- ☑ Diary
  - ☑ PLN 11 (defined Extent of Injury within 60 days)
  - ☐ 8th Day of Disability, Elimination Week & Week 26

Subrogated claim:

- ☐ Notice to claimant
- ☐ Notice to 3rd party
- ☐ Notice to 3rd party insurance
- ☐ Request accident report

Work status change:

- ☐ Update lost time in Allegro
- ☐ Update work status tracking log
- ☐ Copy of work status to Employer

Impairment benefits:

- ☐ EDI 1st report
- ☐ PLN 3
- ☐ Update Allegro MMI/IR
- ☐ Subsequent Status Claim form to Employer
- Request wage statement?

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Toll Free: 866-249-8574 • Fax 979-458-6247 • http://tamusystem.tamu.edu

NOTICE OF DISPUTED ISSUE(s) AND REFUSAL TO PAY BENEFITS

DATE: August 6, 2008

TO: NAME OF INJURED EMPLOYEE:
ADDRESS:
CITY, STATE, ZIP:

FAXED TO STARR
DATE: 8/06/08 KE

RE: DATE OF INJURY: 06/03/2008
NATURE OF INJURY: Possible Exposure/Toxins
PART OF BODY INJURED: Body
EMPLOYEE SSN:
DWC #: Unknown
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 208-0441-02
EMPLOYER NAME: Texas A&M University
EMPLOYER ADDRESS: General Services Complex, Ste. 1201
EMPLOYER CITY, STATE, ZIP: College Station, TX 77843-1255

We are disputing entitlement of any body part, medical condition, or diagnosis other than a possible exposure to Tuberculosis and Brucella because:

The Texas A&M University System as the workers' compensation insurance carrier for Texas A&M University accepts that the compensable injury extends to and includes a possible exposure to tuberculosis and brucella only, that occurred on or about 06/03/2008. Carrier disputes that the compensable injury extends to and includes any and all other body parts and/or medical conditions.

If you do not agree with the dispute and refusal to pay benefits, please contact me:

Adjuster's Name: Kaye Ball
Toll Free Telephone #: 1-866-249-8574
Fax #/E-mail Address: 1-979-458-6247/KBall@tamu.edu

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. Contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

Cc: DWC, 7551 Metro Center Drive, Ste. 100, Austin, Texas 78744-1645

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	4525
CONNECTION TEL	917134624143
CONNECTION ID	
ST. TIME	08/06 12:22
USAGE T	00'56
PGS. SENT	1
RESULT	OK

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Toll Free: 866-249-8574 • Fax 979-458-6247 • http://tamusystem.tamu.edu

NOTICE OF DISPUTED ISSUE(s) AND REFUSAL TO PAY BENEFITS

FAXED TO STARR
DATE: 8/06/08 JE

DATE: August 6, 2008

TO: NAME OF INJURED EMPLOYEE:
ADDRESS:
CITY, STATE, ZIP:

RE: DATE OF INJURY: 06/03/2008
NATURE OF INJURY: Possible Exposure/Toxins
PART OF BODY INJURED: Body
EMPLOYEE SSN:
DWC #: Unknown
CARRIER NAME/TPA NAME: THE TEXAS A&M UNIVERSITY SYSTEM
CARRIER CLAIM#: 208-0441-02
EMPLOYER NAME: Texas A&M University
EMPLOYER ADDRESS: General Services Complex, Ste. 1201
EMPLOYER CITY, STATE, ZIP: College Station, TX 77843-1255

We are disputing entitlement of any body part, medical condition, or diagnosis other than a possible exposure to Tuberculosis and Brucella because:

The Texas A&M University System as the workers' compensation insurance carrier for Texas A&M University accepts that the compensable injury extends to and includes a possible exposure to tuberculosis and brucella only, that occurred on or about 06/03/2008. Carrier disputes that the compensable injury extends to and includes any and all other body parts and/or medical conditions.

If you do not agree with the dispute and refusal to pay benefits, please contact me:

Adjuster's Name: Kaye Ball
Toll Free Telephone #: 1-866-249-8574
Fax #/E-mail Address: 1-979-458-6247/KBall@tamu.edu

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. Contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

Cc: DWC, 7551 Metro Center Drive, Ste. 100, Austin, Texas 78744-1645

INITIAL RESERVES
MEDICAL _____
INDEMNITY _____
LAE _____

LOST TIME Y/N ADJUSTER KB Compensation,

RETAIL RESERVES

CLAIM # _____

CARRIER'S CLAIM # 208-0441-07

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☐ M ☒

3. Social Security Number ✓

4. Home Phone ( )

5. Date of Birth (m-d-y)

6. Does the Employee Speak English? If No, Specify Language
YES ☒ NO ☐

7. Race White ☒ Black ☐ Asian ☐

8. Ethnicity Hispanic ☐ Native American ☐ Other ☒

Cooper Dr. wapsi.com

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name
WAS SEEN BY OC MED OFFICE (BAILEY)

14. Doctor's Mailing Address (Street or P.O. Box)
S&W CLINIC

City COLLEGE STATION State TX Zip Code

15. Date of Injury (m-d-y)
6-3-08

16. Time of Injury am ☐ pm ☒

17. Date Last Time Began (m-d-y)
NLT

18. Nature of Injury*
EXPOSURE

19. Part of Body Injured or Exposed*
RESPIRATORY SYSTEM

20. How and Why Injury/Illness Occurred*
WORKING IN BIOHAZARD SUITE AND NOTICE RESPIRATOR NOT WORKING. WAS ORIGINALLY REPORTED AS 6-13-08 EXPOSURE.

21. Was employee doing his regular job? YES ☒ NO ☐

22. Worksite Location of Injury (state, dock, etc.)*
ABSL3 SUITE

23. Address Where Injury or Exposure Occurred
Name of Business if incident occurred on a business site: CMP
Street or P.O. Box MS 4473 County BZ
City COLLEGE STATION State TX Zip Code 77843-4473

24. Cause of Injury (fall, tool, machine, etc.)*
EQUIPMENT FAILURE ?

25. List Witnesses
NONE

26. Return to work date/or expected (m-d-y)
NLT

27. Did employee die? YES ☐ NO ☒

28. Supervisor's Name
CHRISTIE FICKEY-HAMM

29. Date Reported (m-d-y)
6-3-08

30. Date of Hire (m-d-y)
2-13-08

31. Was employee hired or recruited in Texas? YES ☒ NO ☐

32. Length of Service in Current Position Months 4 Years

33. Length of Service in Occupation Months 4 Years

34. Employee Payroll Classification Code
5068

35. Occupation of Injured Worker
CMP RESEARCH ANIMAL TECHNICIAN II

36. Rate of Pay at this Job
$ 11.21 Hourly $ 448.40 Weekly

37. Full Work Week is:
40 Hours 5 Days

38. Last Paycheck was:
$ 951.46 For 80 Hours or 10 Days

39. Is employee an Owner, Partner, or Corporate Officer?
Yes ☐ No ☒

40. Name and Title of Person Completing Form
DAVID CARLTON

41. Name of Business
TEXAS A&M UNIVERSITY

42. Business Mailing Address and Telephone Number
Street or P.O. Box BLDG 972 AGRONOMY RD
Telephone (979) 845-7433
City COLLEGE STATION State TX Zip Code 77843-4473

43. Business Location (if different from mailing address)
Number and Street 1111 RESEARCH PKWY
City COLLEGE STATION State TX Zip Code 77843-1255

44. Federal Tax Identification Number
74-6000-531

45. Primary North American Industry Classifications System Code (6 digit)
XXXX

46. Specific NAICS Code (6 digit)
XXXX

47. Texas Comptroller Taxpayer No.
XXXX

48. Workers' Compensation Insurance Company
TAMU SYSTEM RISK MANAGEMENT AND SAFETY

49. Policy Number
SELF-INSURED

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☒ If yes, did you receive them? YES ☐ NO ☒

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date 6-19-2008

DWC FORM-1 (Rev. 10/05) Page 3

DIVISION OF WORKERS' COMPENSATION

entered 6/19/08 kr

Coffer, Lisa

From:
Posted At: Thursday, June 19, 2008 5:13 PM
Conversation: correct add.
Posted To: WCI Incoming EMail

Subject: correct add.

Coffer, Lisa

From: Kuhlmann, Jim R.
Sent: Thursday, June 19, 2008 4:09 PM
To: Coffer, Lisa
Subject: address verification

Lisa,

Our records indicate the following address:

Let me know if you need anything else -

Jim Kuhlmann
Human Resources Specialist
Employee Services – Management Services
Texas A&M University
jkuhlmann@tamu.edu

1261 TAMU | College Station, TX 77843-1261

Tel. 979.862.4971| Fax 979.847.8546

http://employees.tamu.edu

208-0441-07

SCOTT & WHITE

MRN: 4661865

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be entitled to certain medical and income benefits. For further information call your local Commission field office or 1(800) 252-7031.

Trabajador - Es necesario que usted reporte su lesión a su empleador dentro de 30 días a partir del día en que se lesionó, si su empleador tiene seguro de compensación para trabajadores. La Comisión Tejana de Compensación para Trabajadores le ofrece asistencia gratuita, también puede que usted tenga derecho a ciertos beneficios médicos y monetarios. Para mayor información llame a la oficina local de la Comisión 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

PART I: GENERAL INFORMATION

5. Doctor's Name and Degree (for transmission purposes only)

Date Being Sent: 6/18/08

Clinic/Facility Name: STW

6. Employer's Name: TAMU

7. Clinic/Facility/Doctor Phone & Fax

10. Employer's Fax # or Email Address (if known)

8. Employee's Description: 6/13/08

9. Clinic/Facility/Doctor Address (street address)

11. Insurance Carrier

City State Zip

12. Carrier's Fax # or Email Address (if known)

ROSS-TB/BrucellaExp

PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE)

13. The injured employee's medical condition resulting from the workers' compensation injury:

- ☐ (a) will allow the employee to return to work as of 6/19/08 (date) without restrictions.
- ☐ (b) will allow the employee to return to work as of _____ (date) with the restrictions identified in PART III, which are expected to last through _____ (date).
- ☐ (c) has prevented and still prevents the employee from returning to work as of _____ (date) and is expected to continue through _____ (date). The following describes how this injury prevents the employee from returning to work:

REASON:

PART III: ACTIVITY RESTRICTIONS* (ONLY COMPLETE IF BOX 13(b) IS CHECKED)

14. POSTURE RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Standing	☐	☐	☐	☐	☐	____
Sitting	☐	☐	☐	☐	☐	____
Kneeling/Squatting	☐	☐	☐	☐	☐	____
Bending/Stooping	☐	☐	☐	☐	☐	____
Pushing/Pulling	☐	☐	☐	☐	☐	____
Twisting	☐	☐	☐	☐	☐	____
Other: _____	☐	☐	☐	☐	☐	____

15. RESTRICTIONS SPECIFIC TO (if applicable):

- ☐ L Hand/Wrist ☐ R Hand/Wrist
- ☐ L Arm ☐ R Arm ☐ Neck
- ☐ L Leg ☐ R Leg ☐ Back
- ☐ L Foot/Ankle ☐ R Foot/Ankle
- ☐ Other: _____

17. MOTION RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Walking	☐	☐	☐	☐	☐	____
Climbing stairs/ladders	☐	☐	☐	☐	☐	____
Grasping/Squeezing	☐	☐	☐	☐	☐	____
Wrist flexion/extension	☐	☐	☐	☐	☐	____
Reaching	☐	☐	☐	☐	☐	____
Overhead Reaching	☐	☐	☐	☐	☐	____
Keyboarding	☐	☐	☐	☐	☐	____
Other: _____	☐	☐	☐	☐	☐	____

18. LIFT/CARRY RESTRICTIONS (if any):

- ☐ May not lift/carry objects more than ____ lbs. for more than ____ hours per day
- ☐ May not perform any lifting/carrying
- ☐ Other: _____

19. MISC. RESTRICTIONS (if any):

- ☐ Max hours per day of work: _____
- ☐ Sit/Stretch breaks of _____ per _____
- ☐ Must wear splint/cast at work
- ☐ Must use crutches at all times
- ☐ No driving/operating heavy equipment
- ☐ Can only drive automatic transmission
- ☐ No work / ☐ ____ hours/day work:
  - ☐ in extreme hot/cold environments
  - ☐ at heights or on scaffolding
- ☐ Must keep _____:
  - ☐ Elevated ☐ Clean & Dry
- ☐ No skin contact with: _____
- ☐ Dressing changes necessary at work
- ☐ No Running

16. OTHER RESTRICTIONS (if any):

20. MEDICATION RESTRICTIONS (if any):

- ☒ Must take prescription medication(s)
- ☐ Advised to take over-the-counter meds
- ☐ Medication may make drowsy (possible safety/driving issues)

* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work.

PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

21. Work Injury Diagnosis Information: Exposure to toxins

22. Expected Follow-up Services Include:

- ☐ Evaluation by the treating doctor on _____ (date) at ____ : ____ am/pm
- ☐ Referral to/Consult with _____ on _____ (date) at ____ : ____ am/pm
- ☐ Physical medicine __ X per week for __ weeks starting on _____ (date) at ____ : ____ am/pm
- ☐ Special studies (list): _____ on _____ (date) at ____ : ____ am/pm
- ☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date / Time of Visit / Discharge Time	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type: ☒ Initial ☐ Follow-up	Role of Doctor: ☒ Treating doctor ☐ Designated doctor ☐ Referral doctor ☐ Carrier-selected RME ☐ Consulting doctor ☐ TWCC-selected RME ☐ Other doctor
Discharge Time		Mm Bailey DO		

TWCC 73 (Rev. 05/00) MR Form 290 9/00 ITEM# 6027

Rule 129.5

Distribution: White - Medical Record Yellow - Employer Pink - Employee

TEXAS WORKERS' COMPENSATION COMMISSION

TAMUS RECORDS VERIFICATION

6/19/08

INJURED EMPLOYEE _____

SOCIAL SECURITY # _____

CLAIM NUMBER	DATE OF INJURY	BODY PART	O	C	DISPOSITION
207-0369-02	1/24/07	Upper Ext; Thumb	✓		M$ 964.91 I$ 0 LAE$ 32.00
207-0229-02	11/30/06	Head; Eye(s)	✓		M$ 11.16 I$ 0 LAE$ 13.50
					M$ I$ LAE$
					M$ I$ LAE$
					M$ I$ LAE$
					M$ I$ LAE$
					M$ I$ LAE$
					M$ I$ LAE$
					M$ I$ LAE$
					M$ I$ LAE$

Revised 9/02
n:\rm\admin\forms\records verification

The Texas A&M University System

Office of the Treasurer

Environmental Health and Safety • Risk Management • Treasury Services
A&M System Building, Suite 1120 • 200 Technology Way • College Station, TX 77845-3424
PH: 979-458-6330 • Fax 979-458-6247 • http://tamusystem.tamu.edu

June 20, 2008

I

This office is in receipt of a First Report of Injury indicating that you sustained a work-related injury on 6/3/2008.

Any medical bills you incur as a direct result of this injury should be immediately forwarded to this office for consideration. Prescription drugs may be filled at any pharmacy. Please do not use your health care insurance to have these prescriptions filled.

If you miss more than a day of work as result of this injury you must contact your department to ensure that you receive all the benefits to which you may be entitled.

If you have any questions regarding your claim, please come by our office or call us at (979) 458-6330.

Sincerely,

Kaye Ball

KAYE BALL
Workers' Compensation Insurance
Risk Management Division

Enclosure

MEDICAL SERVICES CHART

CLAIM# 208-0441-02

CLAIMAN

DOI 8/3/08 Nature of Injury Possible Exposure

Body Part Injured Body

MMI DATE _____ %IMPAIRMENT _____

Treating Dr Don Mordaunt MD

Approved Change _____

Consulting/Referral _____ (approval date)

RME _____ Date _____

Result _____

D/D _____ Date _____

Result _____

Initial Treatment Plan **Initial Diagnosis Code** _____

Secondary Treatment Plan or Changes

X-Ray
Body Part _____ Date _____ Result _____

MRI
Body Part _____ Date _____ Result _____

C/T Scan
Body Part _____ Date _____ Result _____

Bone Scan
Body Part _____ Date _____ Result _____

Myelogram
Body Part _____ Date _____ Result _____

EMG
Body Part _____ Date _____ Result _____

PHYSICAL THERAPY

WEEK 1 _____	WEEK 1 _____
WEEK 2 _____	WEEK 2 _____
WEEK 3 _____	WEEK 3 _____
WEEK 4 _____	WEEK 4 _____
WEEK 5 _____	WEEK 5 _____
WEEK 6 _____	WEEK 6 _____
WEEK 7 _____	WEEK 7 _____
WEEK 8 _____	WEEK 8 _____

COMMENTS: _____

SURGICAL PROCEDURES

_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

DENIED PHARMACY

PREAUTHORIZATIONS

DATE	YES/NO	PROCEDURE

BODY PART DENIED _____
DATE _____ TWCC 21 FILED Y/N
BODY PART DENIED _____
DATE _____ TWCC 21 FILED Y/N
BODY PART DENIED _____
DATE _____ TWCC 21 FILED Y/N
NOTES: _____

208-0441-02 KB

EMRx ID: swsmed09341216852641122 72
Patient Name:
Patient MRN: 4861865
Encounter Date: 07/15/2008
Provider: Samuel W Allen
Facility: CS
Doctype: 09
Specialty:
Marital Status:
DOB: Sex: M Race:
Status: Signed
Phone Number:
Patient Addr:

TITLE: 07/15/2008 BCS WRID Samuel W Allen 4861865

SCOTT AND WHITE MRN: 4861865
Bryan-College Station
Work Related Injury Report
SSN:
DOB: 03/11/1983
DATE OF SERVICE: 07/15/2008

WORKER'S COMPENSATION INJURY

EMPLOYER:
Texas A and M University.

DATE OF INJURY:
June 13, 2008.

I am following this patient for who is the treating physician.

SUBJECTIVE:

208-0441-02 KB

This is a 25-year-old, Caucasian male who presents to Occupational Medicine Clinic. He was originally seen through the TodayCare clinic after a potential exposure to brucella, tuberculosis, and acute fever. On the date of original visit, a chest x-ray was requested. Hemogram laboratory drawn for brucella titer, Q fever. A PPD was also applied to rule out possible exposure. He is here for followup on those labs. He did take the doxycycline which was given as a prophylaxis for possible infection.

PHYSICAL EXAMINATION:
VITAL SIGNS: Pulse of 83. Blood pressure is 147/93. Weight is 178 pounds.

Laboratory review with him today indicates brucella is negative. Q fever less than 1 to 16 which is the normal range. His blood count was reviewed including his WBC count of 8.7, hemoglobin 16.6, hematocrit of 47.2, and platelets of 205,000. He is having no other symptoms. No cough or congestion. No lymph node enlargement or other complaints.

ASSESSMENT:
Possible exposure to Brucella, tuberculosis, Q fever with negative titer, negativePPD.

PLAN:
A Q fever and brucella titer will be drawn today. It is recommended at 90 days, he has a repeat PPD applied. He is given a Texas Worker's Compensation form 73 without restriction today. The laboratory evaluation today will be relayed to the patient once concluded.

Electronically signed by
Don A Mackey, MD 07/23/2008 17:37
Samuel W Allen, PA-C
125 /16997 Don A Mackey, MD
979-691-3458 254-724-2111
dd: 07/15/2008 4:44 P dt: 07/15/2008 9:05 P
Job #: 000368113 / 9826284 /
Doc ID#: 200807152134013500

cc:

208-0441-02 KB

EMRx ID: swlab09341216396068264446
Patient Name:
Patient MRN: 4861865
Order Date: 07/15/2008
Collection Date: 07/15/2008
Received Date: 07/16/2008
Attending Doc: TEST DOCTOR
Consulting Doc: No Data Delivered
Admitting Doc: No Data Delivered
Ordering Doc: SAM ALLEN
Billing Number: 4001091003
Order Number: B5154689
Facility: Scott and White
DOB: Sex: M Race: W
Patient Addr:

Home Phone: (979)845-9012
Work Phone:

TITLE: 07/15/2008 LAB BRUC, QFAB SAM ALLEN DELANEY, JOHN 4861865

SCOTT & WHITE HOSPITAL AND CLINIC
DIVISION OF CLINICAL PATHOLOGY

Name
MRN: 4861865 Loc: BCS CLIN
Age: 25 Sex: M
DOB:
Add:

ELECTRONIC REPORT
PRELIM

Ordered by: ALLEN SAM
Deliver to: ALLEN SAM

Ordered Date&Time : 07/15/2008 16:52
Collected Date&Time: 07/15/2008 16:30
Lab Order #: B5154689

REFERENCE LABS

TEST NAME	RESULTS	AB REF-RANGE	UNITS	SITE
Q FEVER ABS				
COLLECTED 07/15/2008 16:30				
Q-FEVER PHASE I AB IGG	<1:16	<1:16		MAYO
Q-FEVER PHASE II AB IGG	<1:16	<1:16		MAYO
Q-FEVER PHASE I AB IGM	<1:16	<1:16		MAYO
Q-FEVER PHASE II AB IGM	<1:16	<1:16		MAYO
INTERPRETATION	SEE BELOW			MAYO

// Negative
// No antibody detected. Argues against C. burnetii infection.
// This result is seen in persons with either no previous
// C. burnetii infection or with early infection. If early
// acute Q-fever infection is suspected, obtain a second serum
// sample 2-3 weeks later and retest.
//
// Test Performed by:
// Mayo Clinic Dpt of Lab Med and Pathology

208-0441-02 KB

// 200 First Street SW, Rochester, MN 55905
// Laboratory Director: Franklin R. Cockerill, III, M.D.

IMMUNOLOGY

TEST NAME	RESULTS	AB REF-RANGE	UNITS	SITE
MISCELLANEOUS IMMUNOLOGY				
COLLECTED 07/15/2008 16:30				
BRUCELLA AB	NEGATIVE			A
// ***REF RANGE***				
// NEGATIVE OR <1:160				

208-0441-02
KB

EMRx ID: swrad093412139071202275
Patient Name:
Patient MRN: 4861865
Encounter Date: 06/18/2008
Provider: BAILEY MARGARET M
Status: Final
DOB: Sex: M Race: W
Phone Number:
Patient Addr:

Facility: SCOTT AND WHITE

TITLE: 06/18/2008 CHEST 2 VIEWS Final BAILEY MARGARET M 486186

S C O T T & W H I T E
RADIOLOGY

NAME: SEX: M
MRN: AGE: 25Y
DOB: LOC: -
ADR: ORDERED BY: MARGARET M BAILEY
SEND RPT TO: dse
PHONE: ORDERING RES:

DATE OF EXAM: Jun 18 2008 ACCESSION #: 4660983

PROCEDURE REQUESTED - CHEST 2 VIEWS

CLINICAL HISTORY:
COMMENTS:

EXAMINATION: CHEST PA AND LATERAL, 6/18/08.

FINDINGS: Frontal and lateral projections of the chest demonstrate a normal cardiomediastinal silhouette and pulmonary vascular pattern. The lungs are well expanded and clear. No pleural effusion is seen. The visualized bony thorax appears intact.

IMPRESSION: NO ACTIVE DISEASE IS SEEN IN THE CHEST.

DICTATED 06/19/2008 7:38AM BY: DALE S GLASS, MD
TRANSCRIBED 06/19/2008 10:57AM BY: DEJ
ELECTRONICALLY SIGNED 06/19/2008 3:25PM BY: DALE S GLASS, MD

Respons Dr1: INV ORD#: Reviewing Drs. Inits:_____

208-0441-02 KB

EMRx ID: swsmed09341216852641122 72
Patient Name:
Patient MRN: 4861865
Encounter Date: 07/15/2008
Provider: Samuel W Allen
Facility: CS
Doctype: 09
Specialty:
Marital Status:
DOB: Sex: M Race:
Status: Signed
Phone Number:
Patient Addr:

TITLE: 07/15/2008 BCS WRID Samuel W Allen 4861865

SCOTT AND WHITE MRN: 4861865
Bryan-College Station
Work Related Injury Report
SSN:
DOB: 03/11/1983
DATE OF SERVICE: 07/15/2008

WORKER'S COMPENSATION INJURY

EMPLOYER:
Texas A and M University.

DATE OF INJURY:
June 13, 2008.

I am following this patient for who is the treating physician.

SUBJECTIVE:

208-0441-02
KB

General: Well-developed, well-nourished, well-hydrated, alert, cooperative, appropriate, 25-year-old, white male in no distress.
HEENT: TMs are actually retracted and erythematous slightly bilaterally. Oropharynx shows some diffuse erythema, posterior drainage, and scattered cobblestone nodes.
Neck: Supple without lymphadenopathy.
Lungs: Coarse rhonchi bilaterally and there are occasional scattered wheezes that clear with coughing.

Chest x-ray seems to have some increased perihilar markings and possibly an infiltrate on the lateral view posterior to the heart.

IMPRESSION:
1. Sinusitis.
2. Toxic exposure.

PLAN:
1. Doxycycline 100 mg b.i.d. for 10 days.
2. He will not be available to read his skin test until next week so he will return on Monday, June 23, for TB testing.
3. Brucella and Q fever titers were drawn today and CBC was also drawn.

Electronically signed by
Margaret M Bailey, DO 07/01/2008
14:52
Margaret M Bailey, DO
125 / 29260
979-691-3397
dd: 06/18/2008 6:51 P dt: 06/19/2008 9:26 A
Job #: 000348732 - 9697394 -
Doc ID#: 200806182131725700

cc:

208-0441-02
KB

EMRx ID: swlab0934121406027550976
Patient Name:
Patient MRN: 4861865
Order Date: 06/19/2008
Collection Date: 06/18/2008
Received Date: 06/19/2008
Attending Doc: TEST DOCTOR
Consulting Doc: No Data Delivered
Admitting Doc: No Data Delivered
Ordering Doc: MARGARET BAILEY
Billing Number: 4001091003
Order Number: B4185103
Facility: Scott and White
DOB: : M Race: W
Patient Addr:

Home Phone:
Work Phone:

TITLE: 06/18/2008 LAB DIFSS, QFAB, BRUC, CBC MARGARET BAILEY

RECEIVED
08 AUG -6 AM 10:34
TAMUS
OFFICE OF RISK MANAGEMENT

SCOTT & WHITE HOSPITAL AND CLINIC
DIVISION OF CLINICAL PATHOLOGY

ELECTRONIC REPORT
FINAL

Ordered by: BAILEY MARGARET

Deliver to: BAILEY MARGARET

Name
MRN: 4861865 Loc: BCS CLIN
Age: 25 Sex: M
DOB:
Add:

Phone:

Ordered Date&Time : 06/19/2008 07:24
Collected Date&Time: 06/18/2008 17:15
Lab Order #: B4185103

HEMATOLOGY

TEST NAME	RESULTS	AB	REF-RANGE	UNITS	SITE
HEMOGRAM					
COLLECTED 06/18/2008 17:15					
WBC	8.7		4.8-10.8	x10e9/L	A
RBC	4.98		4.70-6.10	x10e12/L	A
HGB	16.6		14.0-18.0	gm/dL	A
HCT	47.2		42.0-52.0	%	A
MCV	94.8	H	80.0-94.0	fL	A
MCH	33.3		27.0-34.5	pg	A
MCHC	35.2		32.0-36.5	gm/dL	A
RDW-CV	13.1		11.0-15.0	%	A
PLT	205		150-450	x10e9/L	A
MPV	13.5	H	7.4-12.0	fL	A
DIFFERENTIAL					
COLLECTED 06/18/2008 17:15					
GRAN %	53		40-80	%	A

LYMPH %	35	15-40	%	A
MONO %	9	0-10	%	A
EOS %	3	0-7	%	A
BASO %	0	0-2	%	A
NRBC (I)	0.0	0.0-0.9	/100^WBC	A
SLIDE ?	YES			A

ABSOLUTE #
COLLECTED 06/18/2008 17:15

GRAN #	4.61	1.92-8.64	x10e9/L	A
LYMPH #	3.05	0.72-4.32	x10e9/L	A
MONO #	0.78	0.00-1.08	x10e9/L	A
EOS #	0.26	0.00-0.76	x10e9/L	A
BASO #	0.00	0.00-0.22	x10e9/L	A

IMMUNOLOGY

TEST NAME	RESULTS	AB REF-RANGE	UNITS	SITE
MISCELLANEOUS IMMUNOLOGY				
COLLECTED 06/18/2008 17:15				
BRUCELLA AB	NEGATIVE			A
// ***REF RANGE***				
// NEGATIVE OR <1:160				

REFERENCE LABS

TEST NAME	RESULTS	AB REF-RANGE	UNITS	SITE
Q FEVER ABS				
COLLECTED 06/18/2008 17:15				
Q-FEVER PHASE I AB IGG	<1:16	<1:16		MAYO
Q-FEVER PHASE II AB IGG	<1:16	<1:16		MAYO
Q-FEVER PHASE I AB IGM	<1:16	<1:16		MAYO
Q-FEVER PHASE II AB IGM	<1:16	<1:16		MAYO
INTERPRETATION	SEE BELOW			MAYO
// Negative				
// No antibody detected. Argues against C. burnetii infection.				
// This result is seen in persons with either no previous				
// C. burnetii infection or with early infection. If early				
// acute Q-fever infection is suspected, obtain a second serum				
// sample 2-3 weeks later and retest.				
//				
// Test Performed by:				
// Mayo Clinic Dpt of Lab Med and Pathology				
// 200 First Street SW, Rochester, MN 55905				
// Laboratory Director: Franklin R. Cockerill, III, M.D.				

HEMATOLOGY

TEST NAME	RESULTS	AB REF-RANGE	UNITS	SITE
HEMOGRAM				
COLLECTED 06/18/2008 17:15				
PLTEST	NL			A
DIFFERENTIAL				

208-0441-02 KB

	COLLECTED 06/18/2008 17:15	
# CELLS COUNTED	SCANNED	A
CELL MORPHOLOGY		
	COLLECTED 06/18/2008 17:15	
RBC MORPHOLOGY	NL	A
** ABNORMAL FLAG PRESENT **		

INITIAL CLAIM QUESTIONNAIRE

Claimant:
Address:

Claim # 208-0441-02
Date of Injury: 06/03/2008
Date mailed: 6/20/2008

Please complete, sign, and date this claims questionnaire and return in the enclosed postage paid envelope as soon as possible.

1. Did your injury occur while performing your normal job duties?

2. Please state in your own words where and how your injury occurred.

3. Please state in your own words any physical harm or damage to your body that resulted from the work related incident.

4. Have you sought medical attention for this injury? If so please indicate your choice of primary care physician. Have you seen this physician in the past three years for other conditions whether work related or not.

5. If you have multiple employers please list the name and address of each employer

Injured employee signature _____ Date _____

c:inques

Ball, Kaye

To:
Subject: Acceptance letter/questionnaire

We had mail returned that was mailed to you at . I am going to resend it today. If this is not correct, please let me know.

Thanks,

Kaye Ball
Claims Adjuster
Risk Management
Phone: 979-458-6330
Fax: 979-458-6247
email: kball@tamu.edu

The Texas A&M University System
Office of Risk Management and Safety
A&M System Building, Suite 1120
200 Technology Way
College Station, Texas 77845-3424

RECEIVED
2008 JUL -7 PM 2:37
TAMUS
OFFICE OF RISK MANAGEMENT

Resent
7/10/08

OFFICIAL
STATE OF
TEXAS MAIL

PENALTY FOR
PRIVATE USE

UNITED STATES POSTAGE
PITNEY BOWES
$ 00.59⁰
02 1A
0004301908 JUN 25 2008
MAILED FROM ZIP CODE 77845

NIXIE 773 DE 1 00 07/03/08
RETURN TO SENDER
ATTEMPTED - NOT KNOWN
UNABLE TO FORWARD
BC: 77845342400 *1700 06442-25-32

77845342400

Hammond SO -11-012-013
TAMUS 0180

WORKERS' COMPENSATION
INITIAL STATUS OF CLAIM REPORT

To:	**Jim Kuhlmann**	Date:	**06/24/08**
	TAMU	RE:	
		Employed By	**TAMU**
		Supervisor:	**Christie Ficke-Hamm**
		D.O.I.:	**06/03/08**
		Claim No.:	**208-0441-02**

PLEASE USE THE INFORMATION BELOW AS YOU DEEM NECESSARY

☐ We have received a medical bill/report that indicates an injury may have occurred on . Please verify with your records. If an injury occurred forward a copy of the Employer's First Report of Injury or your incident/accident report so we may timely process the medical bill. If an injury has not been reported, please notify this office, in writing, as soon as possible. ***If a response is not received within 3 days of receipt of this notice the claim for compensability will be accepted.***

☐ The employer's First Report of Injury has been received. Weekly compensation benefits will begin after the seven day waiting period pursuant to the Texas Workers' Compensation Act if disability continues **unless a Supplemental Report of Injury is received indicating the employee has returned to work or unless the Request for Paid Leave is received indicating that the employee will use sick and or annual leave.** A wage statement is required if the employee is disabled for more than eight days, even if the employee is using sick/annual leave of FMLA leave.

☒ This claim has been accepted as a compensable injury.

☐ This is a questionable claim. However, sufficient evidence does not exist at this time to contest compensability. Please provide us with written witness statements, and any other objective information that would assist us in making a determination of compensability.

☐ This claim has been denied because:
- ☐ There was no injury in course and scope of employment
- ☐ The injury was not sustained in the course & scope of employment
- ☐ Untimely notice of injury was given
- ☐ The injury is considered an ordinary disease of life
- ☐ Disability only, medical documentation required to establish physical harm
- ☐ Other:

☒ Other:
Thanks

Please direct any questions regarding this claim and the above information to:

The Texas A&M University System
Office of Risk Management & Safety
College Station, TX 77845-3424
Phone: 979/458-6330 Fax: 979/458-6247

Adjuster: Kaye Ball
F:wci,procedure;office

DWC #
Carrier's Claim # 208044102 KB

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of injury
		06/03/2008

4. Injured employee's mailing address (Street or P.O. Box)	5. Employer's name and address
	Texas A&M University 1111 Research Park, College Station, TX 77843-1255
6. Health care provider's name and address SCOTT & WHITE P.O. BOX 847408, DALLAS, TX 75284-7408	7. Insurance carrier's name and address Texas A&M University System 200 Technology Way, Suite 1120, College Station, TX 77845-3424
8. Health care provider's federal tax I.D. number 742958277	Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s).
9. Name and address of the company performing the audit Starr Comprehensive Solutions, Inc. P.O. Box 801464, Houston, TX 77280-1464	Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act.
Date of the audit: 09/09/2008	
10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc. Phone: 866-462-4197 Fax: 713-462-4143	ITN Number: 00243455

ICD9 Codes used: 994.9 - OTHER EFFECTS OF EXTERNAL CAUSES

Dates of Service From Date	Thru Date	Procedure Code and Description	Modifier	Units	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
06/18/2008	06/18/2008	86638	WP	1.00	$63.00	$0.00	$0.00	$0.00	B13
				Totals:	**$63.00**	**$0.00**	**$0.00**	**$0.00**	

Reason for Reduction or Denial:
B13 - Previously paid. Payment for this claim/svc may have been provided in a prev payment.

Comments:
B13 - DUPLICATE BILL. PREVIOUSLY AUDITED AND RECOMMENDED FOR PAYMENT. ITN #00242099 AUDIT DATE: 08/20/08

RECEIVED
2008 SEP 10 PM 3:
TAMUS
OFFICE OF RISK MANAGEMENT

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

WC1

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

WORKERS COMPENSATION
TAMU RISK
200 TECHNOLOGY #1120
COLLEGE STATION, TX 77840

PICA ☐☐☐ PICA ☐☐☐

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☒ (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☒ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial) TAMU,
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street) ~~200 TECHNOLOGY WAY~~
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	CITY: COLLEGE STATION / STATE: TX
ZIP CODE / (Include Area Code)		ZIP CODE: 77840 3 / TELEPHONE (Include Area Code): (979) 458-6249
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 208-0441-02 KB	a. EMPLOYMENT? (Current or Previous) ☒ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: WORKERS COMPENSATION
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, return to and complete item 9 a-d.

RECEIVED 2008 AUG 25 AM 11:

OFFICE OF TAMUS RISK MANAGEMENT

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 06/13/08	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: BAILEY, MARGARET M.	17a. OB DOH8967TX / 17b. NPI 1841283348	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 9949 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06/18/08 06/18/08	11		86638	WP 90	1	63 00	1		OB	DOH8967TX
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
742958277 ☐ ☒	822601335B4Q0	☒ YES ☐ NO	$ 63 00	$ 0	$ 63 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
Signature on File DO 08/13/08 SIGNED DATE	CS SCOTT AND WHITE 1600 UNIVERSITY DR EAST COLLEGE STATION TX 77840 a. 1922061993 b. TJ 742958277	(254) -724-2911 SCOTT AND WHITE PO BOX 847408 DALLAS TX 752847408 a. 1922061993 b.

NUCC Instruction Manual available at: www.nucc.org

WCMS-1500CS

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

PAGE 001 DOH8967TX

TL 9/10/2008

Hammond SO -11-012-013
TAMUS 0183

DWC #
Carrier's Claim # 208044102 KB

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of injury
		06/03/2008

4. Injured employee's mailing address (Street or P.O. Box)

5. Employer's name and address
Texas A&M University
1111 Research Park, College Station, TX 77843-1255

6. Health care provider's name and address
SCOTT & WHITE MEM HOSPITAL
P O BOX 847556, DALLAS, TX 752847556

7. Insurance carrier's name and address
Texas A&M University System
200 Technology Way, Suite 1120, College Station, TX 77845-3424

8. Health care provider's federal tax I.D. number
741166904

9. Name and address of the company performing the audit
Starr Comprehensive Solutions, Inc.
P.O. Box 801464, Houston, TX 77280-1464

Date of the audit: 09/08/2008

10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc.
Phone: 866-462-4197 Fax: 713-462-4143

Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s).

Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act.

ITN Number: 00243480

ICD9 Codes used: 994.9 - OTHER EFFECTS OF EXTERNAL CAUSES

Dates of Service From Date	Thru Date	Revenue Code	HCPCS	Rate	Mod	Units	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
06/18/2008	06/18/2008	302	86622	N/A	WP	1.00	$63.00	$0.00	$0.00	$0.00	B13
06/18/2008	06/18/2008	305	85025	N/A		1.00	$60.00	$0.00	$0.00	$0.00	B13
					Totals:		$123.00	$0.00	$0.00	$0.00	

Reason for Reduction or Denial:
B13 - Previously paid. Payment for this claim/svc may have been provided in a prev payment.

Comments:
B13 - DUPLICATE BILL. PREVIOUSLY AUDITED AND RECOMMENDED FOR PAYMENT. ITN #00242704 AUDIT DATE: 08/28/08

RECEIVED
2008 SEP -9 PM 4:19
TAMUS
OFFICE OF RISK MANAGEMENT

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

1 SCOTT AND WHITE MEM HOSP
PO BOX 847556
DALLAS TX 752847556
(254)-724-2911 (254)-724-7715

3a PAT. CNTL # 821001758B4Q0
b. MED. REC. # 0004861865 0131
5 FED. TAX NO. 74-1166904
6 STATEMENT COVERS PERIOD FROM 061808 THROUGH 061808
7

8 PATIENT NAME a b
9 PATIENT ADDRESS a b c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
	M	061808		1	2	10	01	02												

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
	061308													

38 TAMU RISK
~~200 TECHNOLOGY #1120~~
COLLEGE STATION TX 77840-3

39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a 45	13 00				
b					
c					
d					

208-0441-02 KB

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0302	LAB/IMMUNOLOGY	86622 WP	061808	1	63 00		
0305	LAB/HEMATOLOGY	85025	061808	1	60 00		
0001	PAGE 001 OF 001	CREATION DATE	081308	TOTALS	123 00		

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2008 AUG 25 AM 11:52
TAMUS
OFFICE OF RISK MANAGEMENT

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
A WORKERS COMPENSATION		Y	Y		$0	1477516466	450054 B13
B							
C							

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A TAMU 12,WORK COMP	09		UNK	
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		UNK
B		
C		

66 DX											68
	9949										
	5										

69 ADMIT DX	70 PATIENT REASON DX			71 PPS CODE	72 ECI			73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1841283348	QUAL 0B	F06074
LAST BAILEY		FIRST MARGARET	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS
WORKERS COMPENSATION
TAMU RISK
200 TECHNOLOGY 1120
COLLEGE STATION TX 77840

81CC
a B3 282N00000X
b B2 S
c
d

T 9/9/2008

UB-04 CMS-1450 NLCF-UB04-1 APPROVED OMB NO 0938-0997 OCR/Original NUBC 2439480 4001091003

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HERE

TAMUS DEPARTMENT VOUCHER NO 261010# 41241

STATE OF TEXAS PURCHASE VOUCHER

Agency TEXAS A&M UNIVERSITY SYSTEM College Station,TX 77840			Agency Voucher No	
		Order Date 09/10/2008	Requisition No NONE	
	Invoice Date 09/10/2008	Voucher Amount $20.17	Payee Reference No NONE	Control No NONE

Comptroller Vendor ID No 1741166904 NONE	Agency Object	Amount
Pay To (Name, Address, City, State, Zip) SCOTT & WHITE MEM HOSPITAL P O BOX 847556 DALLAS, TX 752847556	6462	$20.17 E N C
Account Name Workers's Compensations Ins.	TOTAL	$20.17

ENCUMBRANCE LEDGER	
Requisition No	Amount

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	Amount
07/15/2008 - 07/15/2008	208044102	$20.17

VENDOR CERTIFICATION
(Use when no invoice is available)
I certify the described articles or services were contracted for and the account is true,correct and unpaid.

SIGNATURE

AGENCY CERTIFICATION
I certify that the above services were rendered,or goods received and that they correspond in every particular with contract under which they were procured and that the invoice is true and unpaid

DATE APPROVED FOR PAYMENT

NAME (PERSON RECEIVING GOODS)	DATE	09/10/2008	NAME
NAME (DEPT HEAD)	DATE	09/10/2008	TITLE

DWC #

Carrier's Claim # 208044102

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of injury
		08/03/2008

4. Injured employee's mailing address (Street or P.O. Box)	5. Employer's name and address
	Texas A&M University 1111 Research Park, College Station, TX 77843-1255
6. Health care provider's name and address SCOTT & WHITE MEM HOSPITAL P O BOX 847556, DALLAS, TX 752847556	7. Insurance carrier's name and address Texas A&M University System 200 Technology Way, Suite 1120, College Station, TX 77845-3424
8. Health care provider's federal tax I.D. number 741166904	Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s). Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act. ITN Number: 00243479
9. Name and address of the company performing the audit Starr Comprehensive Solutions, Inc. P.O. Box 801464, Houston, TX 77280-1464	
Date of the audit: 09/08/2008	
10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc. Phone: 866-462-4197 Fax: 713-462-4143	

ICD9 Codes used: 994.9 - OTHER EFFECTS OF EXTERNAL CAUSES

Dates of Service From Date	Thru Date	Revenue Code	HCPCS	Rate	Mod	Units	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
07/15/2008	07/15/2008	302	86622	N/AWP		1.00	$63.00	$20.17	$0.00	$20.17	W1
				Totals:			$63.00	$20.17	$0.00	$20.17	

Reason for Reduction or Denial:
W1 - Workers Compensation State Fee Schedule Adjustment

RECEIVED
2008 SEP -9 PM 4:19
TAMUS
OFFICE OF RISK MANAGEMENT

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

SCOTT AND WHITE MEM HOSP
PO BOX 847556
DALLAS TX 752847556
(254)-724-2911 (254)-724-7715

CNTL # 022401248B4V0
b. MED. REC. # 000004861865 0131
5 FED. TAX NO. 74-1166904
6 STATEMENT COVERS PERIOD FROM 071508 THROUGH 071508
7

8 PATIENT NAME
9 PATIENT ADDRESS

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACCT STATE	30
	M	071508		1	2	10	01	02												

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37
	061308													

38 TAMU RISK
~~200 TECHNOLOGY #1120~~
COLLEGE STATION TX 77840 3

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	45	13 00				
b						
c						
d						

208-0441-02 KB

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0302	LAB/IMMUNOLOGY	86622 WP	071508	1	63 00	
				TOTALS	63 00	

RECEIVED
2008 AUG 25 AM 11:49
TAMUS
OFFICE OF RISK MANAGEMENT

0001 PAGE 001 OF 001 CREATION DATE 081108

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
WORKERS COMPENSATION		Y	Y		$20.17	1477516466	450054 WI

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
TAMU 12,WORK COMP	09		UNK	

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
		UNK

66 DX: 9949 5 | 68

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1366403552	QUAL 0BC18656
LAST MACKEY	FIRST DON	
77 OPERATING	NPI	QUAL
LAST	FIRST	
78 OTHER	NPI	QUAL
LAST	FIRST	
79 OTHER	NPI	QUAL
LAST	FIRST	

80 REMARKS
WORKERS COMPENSATION
TAMU RISK
200 TECHNOLOGY 1120
COLLEGE STATION TX 77840

81CC
a B3282N00000X
b B2S
c
d

TL 9/10/2008

UB-04 CMS 1450 NUCF 1.0004.1 APPROVED OMB NO. 0938-0997 OCR/Original NUBC 04001091003 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART

TAMUS [illegible] VOUCHER NO 261010# 40818

STATE OF TEXAS PURCHASE VOUCHER

Agency			Agency Voucher No
TEXAS A&M UNIVERSITY SYSTEM College Station,TX 77840	Order Date 09/02/2008		Requisition No NONE
	Invoice Date 09/02/2008	Voucher Amount $33.75	Payee Reference No NONE
			Control No NONE

Comptroller Vendor ID No		Agency Object	Amount
1741166904	NONE	6462	$33.75 E N C

Pay To (Name, Address, City, State, Zip)
SCOTT & WHITE MEM HOSPITAL
P O BOX 847408
DALLAS, TX 752847556

Account Name	TOTAL
Workers's Compensations Ins.	$33.75

ENCUMBRANCE LEDGER

Requisition No	Amount

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	Amount
06/18/2008 - 06/18/2008	208044102	$33.75

VENDOR CERTIFICATION
(Use when no invoice is available)
I certify the described articles or services were contracted for and the account is true,correct and unpaid.

SIGNATURE

AGENCY CERTIFICATION
I certify that the above services were rendered,or goods received and that they correspond in every particular with contract under which they were procured and that the invoice is true and unpaid

DATE APPROVED FOR PAYMENT

NAME (PERSON RECEIVING GOODS)	DATE 09/02/2008	NAME
NAME (DEPT HEAD)	DATE 09/02/2008	TITLE

DWC #

Carrier's Claim # 208044102

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of Injury
		06/03/2008

4. Injured employee's mailing address (Street or P.O. Box)

5. Employer's name and address
Texas A&M University
1111 Research Park, College Station, TX 77843-1255

6. Health care provider's name and address
SCOTT & WHITE MEM HOSPITAL
P O BOX 847408, DALLAS, TX 752847556

7. Insurance carrier's name and address
Texas A&M University System
200 Technology Way, Suite 1120, College Station, TX 77845-3424

8. Health care provider's federal tax I.D. number
741166904

9. Name and address of the company performing the audit
Starr Comprehensive Solutions, Inc.
P.O. Box 801464, Houston, TX 77280-1464

Date of the audit: 08/28/2008

10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc.
Phone: 866-462-4197 Fax: 713-462-4143

Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s).

Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act.

ITN Number: 00242704

ICD9 Codes used: 994.9 - OTHER EFFECTS OF EXTERNAL CAUSES

Dates of Service From Date	Thru Date	Revenue Code	HCPCS	Rate	Mod	Units	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
06/18/2008	06/18/2008	302	86622	N/A	WP	1.00	$63.00	$20.17	$0.00	$20.17	W1
06/18/2008	06/18/2008	305	85025	N/A		1.00	$60.00	$13.58	$0.00	$13.58	W1
					Totals:		$123.00	$33.75	$0.00	$33.75	

Reason for Reduction or Denial:
W1 - Workers Compensation State Fee Schedule Adjustment

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TAMUS
OFFICE OF RISK MANAGEMENT

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

SCOTT AND WHITE MEM HOSP
PO BOX 847556
DALLAS TX 752847556
(254)-724-2911 (254)-724-7715

1a. PAT. REG. # 000004861865
5 FED. TAX I.D. 74-1766904
6 STATEMENT COVERS PERIOD: FROM 061808 THROUGH 061808
7

8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX M
12 ADMISSION DATE 061808
13 HR
14 TYPE 1
15 SRC 2
16 DHR 10
17 STAT 01
CONDITION CODES 02
20 ACCIDENT STATE
31a. OCCURRENCE CODE DATE 061308
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38 TAMU RISK
~~200 TECHNOLOGY #1120~~
COLLEGE STATION TX 77840 3

39 VALUE CODES CODE AMOUNT
a 45 13 00
b
c
d 208-0441-02 KB
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0302	LAB/IMMUNOLOGY	86622 WP	061808	WI 1	~~63 00~~	20.17	
0305	LAB/HEMATOLOGY	85025	061808	WI 1	~~60 00~~	13.58	

TAMUS DEPT VOUCHER NO 261010# 40518

STATE OF TEXAS PURCHASE VOUCHER

Agency TEXAS A&M UNIVERSITY SYSTEM College Station,TX 77840			Agency Voucher No	
	Order Date 08/25/2008		Requisition No NONE	
	Invoice Date 08/25/2008	Voucher Amount $20.72	Payee Reference No NONE	Control No NONE
Comptroller Vendor ID No 1741166904 NONE			Agency Object 6462	Amount $20.72 E N C
Pay To (Name, Address, City, State, Zip) SCOTT AND WHITE P.O. BOX 847408 DALLAS, TX 75284				
Account Name Workers's Compensations Ins.			TOTAL $20.72	

ENCUMBRANCE LEDGER	
Requisition No	Amount

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	Amount
07/15/2008 - 07/15/2008	208044102	$20.72

VENDOR CERTIFICATION
(Use when no invoice is available)
I certify the described articles or services were contracted for and the account is true,correct and unpaid.

SIGNATURE

AGENCY CERTIFICATION
I certify that the above services were rendered,or goods received and that they correspond in every particular with contract under which they were procured and that the invoice is true and unpaid

DATE APPROVED FOR PAYMENT

NAME (PERSON RECEIVING GOODS)	DATE	08/25/2008	NAME	
NAME (DEPT HEAD)	DATE	08/25/2008	TITLE	

DWC #

Carrier's Claim # 208044102

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of Injury
		06/03/2008

4. Injured employee's mailing address (Street or P.O. Box)	5. Employer's name and address
	Texas A&M University 1111 Research Park, College Station, TX 77843-1255
6. Health care provider's name and address SCOTT AND WHITE P.O. BOX 847408, DALLAS, TX 75284	7. Insurance carrier's name and address Texas A&M University System 200 Technology Way, Suite 1120, College Station, TX 77845-3424
8. Health care provider's federal tax I.D. number 741166904	Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s). Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act. ITN Number: 00242102
9. Name and address of the company performing the audit Starr Comprehensive Solutions, Inc. P.O. Box 801464, Houston, TX 77280-1464	
Date of the audit: 08/20/2008	
10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc. Phone: 866-462-4197 Fax: 713-462-4143	

ICD9 Codes used: 994.9 - OTHER EFFECTS OF EXTERNAL CAUSES

Dates of Service From Date	Thru Date	Procedure Code and Description	Modifier	Units	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
07/15/2008	07/15/2008	36415 COLLECTION, VENOUS BLOOD, VENIPUNCTURE		1.00	$17.00	$0.00	$0.00	$0.00	97
07/15/2008	07/15/2008	86638 ANTIBODY; COXIELLA BRUNETII (Q FEVER)		1.00	$63.00	$20.72	$0.00	$20.72	W1
		Totals:			**$80.00**	**$20.72**	**$0.00**	**$20.72**	

Reason for Reduction or Denial:

W1 - Workers Compensation State Fee Schedule Adjustment

97 - Payment is included in the allowance for another service/procedure

Comments:

97 - THE VENIPUNCTURE IS GLOBAL OF THE REIMBURSEMENT FOR LAB.

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TAMUS
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TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

WC1

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

WORKERS COMPENSATION
TAMU RISK
200 TECHNOLOGY #1120
COLLEGE STATION, TX 77840

PICA ☐☐☐ PICA ☐☐☐

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☒ (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M ☒ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial) TAMU,
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street) ~~200 TECHNOLOGY WAY~~
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	CITY COLLEGE STATION / STATE TX
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE 77843 / TELEPHONE (Include Area Code) (979) 458-6249
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER 208-0441-02 KB	a. EMPLOYMENT? (Current or Previous) ☒ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME WORKERS COMPENSATION
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 06/13/08 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE ALLEN, SAM	17a. OB PAPA00825TX / 17b. NPI 1982667283	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / MM DD YY TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☒ NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 9949 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07/15/08 07/15/08	11		36415		1	17 00	1		OB PAPA00825TX / NPI 1982667283	
2 07/15/08 07/15/08	11		86638	WP 90	1	63 00	1		OB PAPA00825TX / NPI 1982667283	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
741166904 ☐ ☒	821001944B4Q0	☒ YES ☐ NO	$ 80 00	$ 20.12	$ 80 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (254)-724-2911
Signature on File PA 07/28/08 SIGNED DATE	CS SCOTT AND WHITE 1600 UNIVERSITY DR EAST COLLEGE STATION TX 77840 a. 1922061993 b. TJ 742958277	SCOTT AND WHITE PO BOX 847408 DALLAS TX 752847408 a. 1932164399 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/

WCMS-1500CS

PAGE 001 PAPA00825TX

TL 8/22/2008

Hammond SO -11-012-013
TAMUS 0194

TAMUS DEPT VOUCHER NO 261010# 40517

STATE OF TEXAS PURCHASE VOUCHER

Agency
TEXAS A&M UNIVERSITY SYSTEM
College Station,TX 77840

Agency Voucher No

Order Date: 08/25/2008
Requisition No: NONE

Invoice Date: 08/25/2008
Voucher Amount: $119.12
Payee Reference No: NONE
Control No: NONE

Comptroller Vendor ID No: 1742958277 NONE

Pay To (Name, Address, City, State, Zip)
SCOTT & WHITE
P.O. BOX 847408
DALLAS, TX 75284-7408

Agency Object	Amount
6462	$119.12 E N C

Account Name: Workers's Compensations Ins.

TOTAL: $119.12

ENCUMBRANCE LEDGER

Requisition No	Amount

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	Amount
07/15/2008 - 07/15/2008	208044102	$119.12

VENDOR CERTIFICATION
(Use when no invoice is available)
I certify the described articles or services were contracted for and the account is true,correct and unpaid.

SIGNATURE

AGENCY CERTIFICATION
I certify that the above services were rendered,or goods received and that they correspond in every particular with contract under which they were procured and that the invoice is true and unpaid

DATE APPROVED FOR PAYMENT

NAME (PERSON RECEIVING GOODS) DATE 08/25/2008

NAME (DEPT HEAD) DATE 08/25/2008

NAME

TITLE

DWC #

Carrier's Claim # 208044102

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of injury
		06/03/2008

4. Injured employee's mailing address (Street or P.O. Box)	5. Employer's name and address
	Texas A&M University 1111 Research Park, College Station, TX 77843-1255
6. Health care provider's name and address SCOTT & WHITE P.O. BOX 847408, DALLAS, TX 75284-7408	7. Insurance carrier's name and address Texas A&M University System 200 Technology Way, Suite 1120, College Station, TX 77845-3424
8. Health care provider's federal tax I.D. number 742958277	Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s). Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act. ITN Number: 00242101
9. Name and address of the company performing the audit Starr Comprehensive Solutions, Inc. P.O. Box 801464, Houston, TX 77280-1464	
Date of the audit: 08/20/2008	
10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc. Phone: 866-462-4197 Fax: 713-462-4143	

ICD9 Codes used: 987.9 - TOXIC EFFECT OF UNSPECIFIED GAS FUME OR VAPOR

Dates of Service From Date	Thru Date	Procedure Code and Description	Modifier	Units	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
07/15/2008	07/15/2008	99203 OFFICE/OP VISIT, NEW PT, 3 KEY COMPONENTS: DETAILED HX; DETAILED EXAM; MED DECIS		1.00	$174.00	$119.12	$0.00	$119.12	W1
			Totals:		$174.00	$119.12	$0.00	$119.12	

Reason for Reduction or Denial:
W1 - Workers Compensation State Fee Schedule Adjustment

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TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

WC1

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

WORKERS COMPENSATION
TAMU RISK
200 TECHNOLOGY #1120
COLLEGE STATION, TX 77840

CARRIER

PICA ☐☐☐ PICA ☐☐☐

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☒ (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) [redacted]
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M ☒ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial) TAMU,
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street) ~~2 TECHNOLOGY WAY~~
CITY	STATE TX	8. PATIENT STATUS Single ☐ Married ☐ Other ☐
TELEPHONE (Include Area Code)		Employed ☐ Full-Time Student ☐ Part-Time Student ☐
		CITY COLLEGE STATION STATE TX
		ZIP CODE 77843 TELEPHONE (Include Area Code) (979) 458-6249
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER 208-0441-02 KB	a. EMPLOYMENT? (Current or Previous) ☒ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME WORKERS COMPENSATION
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, return to and complete item 9 a-d.

OFFICE OF RISK MANAGEMENT AUG 6 2008 RECEIVED

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 06/13/08	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI 1366403552	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 9879 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07/15/08	07/15/08	11		99203		1	174 00	1		OB	MDB1032TX NPI 1366403552
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
742958277 ☐ ☒	821001034B4Q0	☒ YES ☐ NO	$ 174 00	$ 119.12	$ 174 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. #
Signature on File MD 07/28/08 SIGNED DATE	CS SCOTT AND WHITE 1600 UNIVERSITY DR EAST COLLEGE STATION TX 77840	SCOTT AND WHITE PO BOX 847408 DALLAS TX 752847408 (254)-724-2911
	a. 1922061993 b. TJ 742958277	a. 1922061993 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/

WCMS-1500CS

TL 8/22/2008

Hammond SO -11-012-013
TAMUS 0197

TAMUS DEPT VOUCHER NO 261010# 40514

STATE OF TEXAS PURCHASE VOUCHER

Agency		Agency Voucher No	
TEXAS A&M UNIVERSITY SYSTEM College Station,TX 77840	Order Date: 08/25/2008	Requisition No: NONE	
	Invoice Date: 08/25/2008	Voucher Amount: $20.72	Payee Reference No: NONE
	Control No: NONE		

Comptroller Vendor ID No		Agency Object	Amount
1742958277	NONE	6462	$20.72 E N C

Pay To (Name, Address, City, State, Zip)
SCOTT & WHITE
P.O. BOX 847408
DALLAS, TX 75284-7408

Account Name	TOTAL
Workers's Compensations Ins.	$20.72

ENCUMBRANCE LEDGER

Requisition No	Amount

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES		Amount
06/18/2008 - 06/18/2008		208044102	$20.72

VENDOR CERTIFICATION
(Use when no invoice is available)
I certify the described articles or services were contracted for and the account is true,correct and unpaid.

SIGNATURE

AGENCY CERTIFICATION
I certify that the above services were rendered,or goods received and that they correspond in every particular with contract under which they were procured and that the invoice is true and unpaid

DATE APPROVED FOR PAYMENT

NAME (PERSON RECEIVING GOODS)	DATE	08/25/2008	NAME
NAME (DEPT HEAD)	DATE	08/25/2008	TITLE

DWC #

Carrier's Claim # 208044102

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of injury
		06/03/2008

4. Injured employee's mailing address (Street or P.O. Box)	5. Employer's name and address
	Texas A&M University 1111 Research Park, College Station, TX 77843-1255
6. Health care provider's name and address SCOTT & WHITE P.O. BOX 847408, DALLAS, TX 75284-7408	7. Insurance carrier's name and address Texas A&M University System 200 Technology Way, Suite 1120, College Station, TX 77845-3424
8. Health care provider's federal tax I.D. number 742958277	Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s).
9. Name and address of the company performing the audit Starr Comprehensive Solutions, Inc. P.O. Box 801464, Houston, TX 77280-1464	Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act.
Date of the audit: 08/20/2008	
10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc. Phone: 866-462-4197 Fax: 713-462-4143	ITN Number: 00242099

ICD9 Codes used: 994.9 - OTHER EFFECTS OF EXTERNAL CAUSES

Dates of Service From Date	Thru Date	Procedure Code and Description	Modifier	Units	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
06/18/2008	06/18/2008	36415 COLLECTION, VENOUS BLOOD, VENIPUNCTURE		1.00	$17.00	$0.00	$0.00	$0.00	97
06/18/2008	06/18/2008	86638 ANTIBODY; COXIELLA BRUNETII (Q FEVER)	WP	1.00	$63.00	$20.72	$0.00	$20.72	W1
			Totals:		$80.00	$20.72	$0.00	$20.72	

Reason for Reduction or Denial:

W1 - Workers Compensation State Fee Schedule Adjustment

97 - Payment is included in the allowance for another service/procedure

Comments:

97 - THE INJECTION IS GLOBAL OF THE REIMBURSEMENT FOR EVALUATION AND MANAGEMENT.

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TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

WC1

WORKERS COMPENSATION
TAMU RISK
200 TECHNOLOGY #1120
COLLEGE STATION, TX 77840

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): TAMU,

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street): ~~200 TECHNOLOGY WAY~~

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY: COLLEGE STATION STATE: TX

ZIP CODE: 77843 TELEPHONE (Include Area Code): (979) 458-6249

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 208-0441-02 ICB

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) X YES NO

b. AUTO ACCIDENT? YES X NO PLACE (State)

c. OTHER ACCIDENT? YES X NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME: WORKERS COMPENSATION

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d.

2008 AUG 16 AM 10:33 RISK MGMT

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 06/13/08

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. ~~OB~~ DOH8967TX

17b. NPI 1841283348

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 9949 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06/18/08	06/18/08	11		36415		1	17 00	1		OB	DOH8967TX
										NPI	1841283348
2 06/18/08	06/18/08	11		86638	WP	1	63 00	1		OB	DOH8967TX
										NPI	1841283348
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
742958277 X	821001757B4Q0	X YES NO	$ 80 00	$ 2012	$ 80 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File DO 07/28/08

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
CS SCOTT AND WHITE
1600 UNIVERSITY DR EAST
COLLEGE STATION TX 77840

a. 1922061993 b. TJ 742958277

33. BILLING PROVIDER INFO & PH # (254)-724-2911
SCOTT AND WHITE
PO BOX 847408
DALLAS TX 752847408

a. 1922061993 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM 1500 (08/0

WCMS-1500CS

TC 8/22/2008

Hammond SO -11-012-013
TAMUS 0200

WC1

WORKERS COMPENSATION
TAMU RISK
200 TECHNOLOGY #1120
COLLEGE STATION, TX 77840

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) TAMU,
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self / Spouse / Child / Other	7. INSURED'S ADDRESS (No., Street) ~~200 TECHNOLOGY #1120~~
	8. PATIENT STATUS Single / Married / Other; Employed / Full-Time Student / Part-Time Student	CITY COLLEGE STATION; STATE TX; ZIP CODE 77843; TELEPHONE (Include Area Code) (979) 458-6249
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER 208-0441-02 ICB	a. EMPLOYMENT? (Current or Previous) X YES / NO	a. INSURED'S DATE OF BIRTH MM DD YY; SEX M / F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX M / F	b. AUTO ACCIDENT? YES / X NO; PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME WORKERS COMPENSATION
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / X NO If yes, return to and complete item 9 a-d.

2008 AUG -6 AM 10:39 RECEIVED

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 06/13/08	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. ~~OB DOH8967TX~~ 17b. NPI 1841283348	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES / X NO; $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 9949 2. 3. 4.		22. MEDICAID RESUBMISSION CODE; ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06/18/08	06/18/08	11		36415		1	17 00	1		OB NPI	DOH8967TX 1841283348
2 06/18/08	06/18/08	11		86638	WP	1	63 00	1		OB NPI	DOH8967TX 1841283348
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES / NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
742958277 X	821001757B4Q0	X YES / NO	$ 80 00	$ 2012	$ 80 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (254)-724-2911
Signature on File DO 07/28/08 SIGNED DATE	CS SCOTT AND WHITE 1600 UNIVERSITY DR EAST COLLEGE STATION TX 77840	SCOTT AND WHITE PO BOX 847408 DALLAS TX 752847408
	a. 1922061993 b. TJ 742958277	a. 1922061993 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/0

WCMS-1500CS

TC 8/22/2008

Hammond SO -11-012-013
TAMUS 0201

TAMUS DEPT ER NO 261010# 40513

STATE OF TEXAS PURCHASE VOUCHER

Agency TEXAS A&M UNIVERSITY SYSTEM College Station,TX 77840			Agency Voucher No	
		Order Date 08/25/2008	Requisition No NONE	
	Invoice Date 08/25/2008	Voucher Amount $41.94	Payee Reference No NONE	Control No NONE
Comptroller Vendor ID No 1742958277 NONE			Agency Object	Amount
Pay To (Name, Address, City, State, Zip) SCOTT & WHITE P.O. BOX 847408 DALLAS, TX 75284-7408			6462	$41.94 E N C
Account Name Workers's Compensations Ins.			TOTAL $41.94	

ENCUMBRANCE LEDGER	
Requisition No	Amount

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	Amount
06/18/2008 - 06/18/2008	208044102	$41.94

VENDOR CERTIFICATION
(Use when no invoice is available)
I certify the described articles or services were contracted for and the account is true,correct and unpaid.

SIGNATURE

AGENCY CERTIFICATION
I certify that the above services were rendered,or goods received and that they correspond in every particular with contract under which they were procured and that the invoice is true and unpaid

DATE APPROVED FOR PAYMENT

NAME (PERSON RECEIVING GOODS)	DATE	08/25/2008	NAME	
NAME (DEPT HEAD)	DATE	08/25/2008	TITLE	

DWC #

Carrier's Claim # 208044102

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of injury
		06/03/2008

4. Injured employee's mailing address (Street or P.O. Box)

5. Employer's name and address
Texas A&M University
1111 Research Park, College Station, TX 77843-1255

6. Health care provider's name and address
SCOTT & WHITE
P.O. BOX 847408, DALLAS, TX 75284-7408

7. Insurance carrier's name and address
Texas A&M University System
200 Technology Way, Suite 1120, College Station, TX 77845-3424

8. Health care provider's federal tax I.D. number
742958277

9. Name and address of the company performing the audit
Starr Comprehensive Solutions, Inc.
P.O. Box 801464, Houston, TX 77280-1464

Date of the audit: 08/20/2008

10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc.
Phone: 866-462-4197 Fax: 713-462-4143

Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s).

Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act.

ITN Number: 00242098

ICD9 Codes used: V01.1 - CONTACT WITH OR EXPOSURE TO TUBERCULOSIS

Dates of Service From Date	Thru Date	Procedure Code and Description	Modifier	Units	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
06/18/2008	06/18/2008	71020 RADIOLOGIC EXAM, CHEST, 2 VIEWS, FRONTAL & LATERAL	WP	1.00	$126.00	$41.94	$0.00	$41.94	W1
		Totals:			**$126.00**	**$41.94**	**$0.00**	**$41.94**	

Reason for Reduction or Denial:
W1 - Workers Compensation State Fee Schedule Adjustment

RECEIVED
2008 AUG 22 PM 2:53
TAMUS
OFFICE OF RISK MANAGEMENT

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

WC1

WORKERS COMPENSATION
TAMU RISK
200 TECHNOLOGY #1120
COLLEGE STATION, TX 77840

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	
						X	

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY — SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): TAMU,

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 200 TECHNOLOGY WAY

CITY: COLLEGE STATION — STATE: TX

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

ZIP CODE: 77843 — TELEPHONE (Include Area Code): (979) 458-6249

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 208-0441-02-KB

a. EMPLOYMENT? (Current or Previous): X YES NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M F

b. AUTO ACCIDENT? YES X NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: WORKERS COMPENSATION

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO — If yes, return to and complete Item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE — DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 06/13/08

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM — TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: BAILEY, MARGARET M.

17a. OB DOB896TTX

17b. NPI 1184684888

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. V011
2.
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06/18/08	06/18/08	11		71020	WP	1	126 00	1		OB	MDH6245TX
										NPI	1184684888
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
742958277	X	821001114B4Q0	X YES NO	$ 126 00	$ 41.91	$ 126 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File MD

SIGNED — DATE 07/28/08

32. SERVICE FACILITY LOCATION INFORMATION

CS SCOTT AND WHITE
1600 UNIVERSITY DR EAST
COLLEGE STATION TX 77840

a. 1922061993 b. TJ 742958277

33. BILLING PROVIDER INFO & PH. # (254)-724-2911

SCOTT AND WHITE
PO BOX 847408
DALLAS TX 752847408

a. 1922061993 b.

NUCC Instruction Manual available at: www.nucc.org

WCMS-1500CS

APPROVED OMB-0938-0999 FORM CMS-1500 (08

PAGE 001

MDH6245TX

TL 8/22/2008

Hammond SO -11-012-013
TAMUS 0204

TAMUS DEPARTMENT VOUCHER NO 261010# 40512

STATE OF TEXAS PURCHASE VOUCHER

Agency TEXAS A&M UNIVERSITY SYSTEM College Station,TX 77840			Agency Voucher No	
		Order Date 08/25/2008	Requisition No NONE	
	Invoice Date 08/25/2008	Voucher Amount $78.14	Payee Reference No NONE	Control No NONE
Comptroller Vendor ID No 1742958277 NONE			Agency Object	Amount
Pay To (Name, Address, City, State, Zip) SCOTT & WHITE P.O. BOX 847408 DALLAS, TX 75284-7408			6462	$78.14 E N C
Account Name Workers's Compensations Ins.			TOTAL $78.14	

ENCUMBRANCE LEDGER	
Requisition No	Amount

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	Amount
06/18/2008 - 06/18/2008	208044102	$78.14

VENDOR CERTIFICATION
(Use when no invoice is available)
I certify the described articles or services were contracted for and the account is true,correct and unpaid.

SIGNATURE

AGENCY CERTIFICATION
I certify that the above services were rendered,or goods received and that they correspond in every particular with contract under which they were procured and that the invoice is true and unpaid

DATE APPROVED FOR PAYMENT

NAME (PERSON RECEIVING GOODS)	DATE	08/25/2008	NAME
NAME (DEPT HEAD)	DATE	08/25/2008	TITLE

DWC #
Carrier's Claim # 208044102

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of injury
	8485	06/03/2008

4. Injured employee's mailing address (Street or P.O. Box)	5. Employer's name and address
	Texas A&M University 1111 Research Park, College Station, TX 77843-1255
6. Health care provider's name and address SCOTT & WHITE P.O. BOX 847408, DALLAS, TX 75284-7408	7. Insurance carrier's name and address Texas A&M University System 200 Technology Way, Suite 1120, College Station, TX 77845-3424
8. Health care provider's federal tax I.D. number 742958277	insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s). Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act. ITN Number: 00242100
9. Name and address of the company performing the audit Starr Comprehensive Solutions, Inc. P.O. Box 801464, Houston, TX 77280-1464 Date of the audit: 08/20/2008	
10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc. Phone: 866-462-4197 Fax: 713-462-4143	

ICD9 Codes used: V01.1 - CONTACT WITH OR EXPOSURE TO TUBERCULOSIS
461.9 - ACUTE SINUSITIS UNSPECIFIED

Dates of Service From Date	Thru Date	Procedure Code and Description	Modifier	Units	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
06/18/2008	06/18/2008	99213 OFFICE/OP VISIT, EST PT, 2 KEY COMPONENTS: EXPAND PROB HX; EXPAND PROB EXAM;MED		1.00	$113.00	$78.14	$0.00	$78.14	W1
				Totals:	**$113.00**	**$78.14**	**$0.00**	**$78.14**	

Reason for Reduction or Denial:
W1 - Workers Compensation State Fee Schedule Adjustment

RECEIVED
2008 AUG 22 PM 2:53
TAMUS
OFFICE OF RISK MANAGEMENT

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

WC1

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

WORKERS COMPENSATION
TAMU RISK
200 TECHNOLOGY #1120
COLLEGE STATION, TX 77840

CARRIER

PICA ☐☐☐ | PICA ☐☐☐

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | TRICARE CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (Member ID#) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
TAMU,

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)
~~200 TECHNOLOGY WAY~~

8. PATIENT STATUS
Single ☐ Married ☐ Other ☐
Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: COLLEGE STATION | STATE: TX

ZIP CODE: 77840 3 | TELEPHONE (Include Area Code): (979) 458-6249

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER
208-0441-02 KD

a. EMPLOYMENT? (Current or Previous) ☒ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☒ NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME
WORKERS COMPENSATION

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

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SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)
06/13/08

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI 1841293348

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. V011
2. 4619
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	06/18/08	06/18/08	11		99213		1	113 00	1		0B DOR896772
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 742958277 SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: 821001757B4Q0

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE: $ 113 00

29. AMOUNT PAID: $ 78.14

30. BALANCE DUE: $ 113 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Signature on File DO
07/28/08
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
CE BCS URGENT CARE
1600 UNIVERSITY DR EAST
COLLEGE STATION TX 77840
a. 1093779704 b. TJ 742958277

33. BILLING PROVIDER INFO & PH. # (254)-724-2911
SCOTT AND WHITE
PO BOX 847408
DALLAS TX 752847408
a. 1922061993 b.

NUCC Instruction Manual available at: www.nucc.org

WCMS-1500CS

TL 8/22/2008

APPROVED OMB-0938-0999 FORM CMS-1500 (08/

PAGE 001 DOR896772X

Hammond SO -11-012-013
TAMUS 0207

TAMUS DEPT VOUCHER NO 261010# 39637

STATE OF TEXAS PURCHASE VOUCHER

Agency TEXAS A&M UNIVERSITY SYSTEM College Station,TX 77840			Agency Voucher No	
	Order Date 07/29/2008		Requisition No	NONE
	Invoice Date 07/29/2008	Voucher Amount $32.48	Payee Reference No NONE	Control No NONE
Comptroller Vendor ID No 1621770924	NONE		Agency Object	Amount
Pay To (Name, Address, City, State, Zip) THIRD PARTY SOLUTIONS, INC PO BOX 100994 ATLANTA, GA 30384			6462	$32.48 E N C
Account Name Workers's Compensations Ins.			TOTAL	$32.48

ENCUMBRANCE LEDGER	
Requisition No	Amount

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	Amount
06/18/2008 - 06/18/2008	208044102	$32.48

VENDOR CERTIFICATION
(Use when no invoice is available)
I certify the described articles or services were contracted for and the account is true,correct and unpaid.

SIGNATURE

AGENCY CERTIFICATION
I certify that the above services were rendered,or goods received and that they correspond in every particular with contract under which they were procured and that the invoice is true and unpaid

DATE APPROVED FOR PAYMENT

NAME (PERSON RECEIVING GOODS)	DATE	07/29/2008	NAME
NAME (DEPT HEAD)	DATE	07/29/2008	TITLE

DWC #

Carrier's Claim # 208044102

DWC FORM-62
EXPLANATION OF BENEFITS

1. Injured employee's name (Last, First, M.I.)	2. Injured employee's Social Security number	3. Date of injury
		06/03/2008

4. Injured employee's mailing address (Street or P.O. Box)	5. Employer's name and address
	Texas A&M University 1111 Research Park, College Station, TX 77843-1255
6. Health care provider's name and address THIRD PARTY SOLUTIONS, INC PO BOX 100994, ATLANTA, GA 30384	7. Insurance carrier's name and address Texas A&M University System 200 Technology Way, Suite 1120, College Station, TX 77845-3424
8. Health care provider's federal tax I.D. number 621770924	Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s). Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of liability under '408.024 of the Texas Workers' Compensation Act. ITN Number: 00240645
9. Name and address of the company performing the audit Starr Comprehensive Solutions, Inc. P.O. Box 801464, Houston, TX 77280-1464	
Date of the audit: 07/23/2008	
10. Name and telephone number of the person who can be contacted about the bill reduction: Starr Comprehensive Solutions, Inc. Phone: 866-462-4197 Fax: 713-462-4143	

Date	Rx. #	NDC #	Day Supply	Which Refill #	Generic Drug	Quantity	Billed Amount	Allowed Amount	Discount Amount	Total Allowance	EOB Code(s)
Product/Strength						Doctor					
06/18/2008	03142	00143314205	10	0	Yes	20.00	$32.48	$32.48	$0.00	$32.48	
DOXYCYCLINE HYCLATE/100 MG						MARGARET BAILEY					
						Totals:	**$32.48**	**$32.48**	**$0.00**	**$32.48**	

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TAMUS
OFFICE OF RISK MANAGEMENT

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION

00287 3901729 004426 004426 00009/00019

TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION STATEMENT OF PHARMACY SERVICES

Send this form to the injured employee's workers' compensation insurance carrier.

Coverage Verification

☒ In accordance with Rule 134.501, I affirm that I have verified the workers' compensation insurance coverage for this employer, confirmed that a work-related injury of the employee named below has been reported to the employer for the listed date of injury, and have kept documentation regarding the means of verification/confirmation on file. (See DCW FORM-66 Instructions for the Verification Statement.)

Section 1

1. Pharmacy's Name, Address, and Phone #: CVS PHARMACY 3000 S TEXAS AVE BRYAN, TX 77802 Phone (979) 822-7344 Fax (979) 823-4890	**2. Date of Billing:** 07/02/08 **3. Pharmacy's NCPDP #:** (NPI #): 4506955 1376647180
4. Remit Payment To (if different from above): THIRD PARTY SOLUTIONS, INC. P.O. BOX 100994 ATLANTA, GA 30384-0994	**5. Invoice #:** 26098745 **6. Payee's FEIN:** 62-1770924
7. Carrier's Name and Address: TEXAS A & M UNIVERSITY SYSTEM ATTN: KAY BALL 200 TECHNOLOGY WAY STE 1120 COLLEGE STATION, TX 77845-3424	**8. Employer's Name, Address, and Phone #:** TEXAS A&M UNIVERSITY SYSTEM 200 TECHNOLOGY WAY COLLEGE STATION, TX 77845-3424 (979) 845-3211
9. Injured Employee's Name, Address, and Phone #:	**15. Prescribing Doctor's Name, Address, and Phone #:** BAILEY MARGARET M DO 112 W JONES , DIMMITT, TX 79027 (979) 691-3300
10a. Injured Employee's ID # **10b. ID Jurisdiction**: U.S. **10c.** ☒ SSN ☐ DL# ☐ Passport ☐ Visa ☐ Green Card	**16. Prescribing Doctor's DEA#:** (NPI #): BB2634601 1841283346
11. DOI: 06/03/08 **12. DOB:** **13. Claim # (if known):**	**14. Carrier's Claim # (if known):** 208044102

2008 JUL 14 AM 11:29 RECEIVED

OFFICE OF INJURED EMPLOYEE

Section 2

17. ☒ Generic Dispensed ☐ Name Brand Dispensed		**18. Generic Available?** ☐ YES ☐ NO		**19.** ☐ Dispensed as Written ☐ Dispensed per Injured Employee request		
20. Date filled: 06/18/08	**21. Generic NDC:** 00143314205	**22. Name Brand NDC:**	**23. Quantity:** 20.000	**24. Days Supply:** 10	**25. Refills Remaining:** 0	**26. Paid by Employee:**
27. Drug Name and Strength: DOXYCYCL HYC CAP 100MG			**28. Rx #:** 0314286			**29. Amount Billed:** 32.48
17. ☐ Generic Dispensed ☐ Name Brand Dispensed		**18. Generic Available?** ☐ YES ☐ NO		**19.** ☐ Dispensed as Written ☐ Dispensed per Injured Employee request		
20. Date filled:	**21. Generic NDC:**	**22. Name Brand NDC:**	**23. Quantity:**	**24. Days Supply:**	**25. Refills Remaining:**	**26. Paid by Employee:**
27. Drug Name and Strength:			**28. Rx #:**			**29. Amount Billed:**
17. ☐ Generic Dispensed ☐ Name Brand Dispensed		**18. Generic Available?** ☐ YES ☐ NO		**19.** ☐ Dispensed as Written ☐ Dispensed per Injured Employee request		
20. Date filled:	**21. Generic NDC:**	**22. Name Brand NDC:**	**23. Quantity:**	**24. Days Supply:**	**25. Refills Remaining:**	**26. Paid by Employee:**
27. Drug Name and Strength:			**28. Rx #:**			**29. Amount Billed:**

INVOICE # 26098745 TOTAL 32.48

TC 7/25/08