AUTHORIZATION FOR INITIAL TREATMENT AND PHARMACY

State Employee Injury Compensation Trust Fund
SEICTF

TO BE COMPLETED BY EMPLOYEE
If you desire program benefits, read and sign below. Benefits will not be authorized without your signature.

I hereby authorize any physician, health care professional, hospital, or other medical care facility to provide my complete health care records to representatives of SEICTF (State Employee Injury Compensation Trust Fund), and/or its' agents regarding my health and any treatment rendered. I authorize representatives of SEICTF and/or its' agents to examine any and all records including but not limited to: all history and physical examinations; progress notes; physicians' notes; lab reports; x-ray, MRI, CT scans, myelograms and all other diagnostic procedure reports; all consultation reports and records, in-patient and out-patient facility records; operative reports; payment records; prescribed medications; and all notes, correspondence and records of any kind.

In addition, I authorize the release of information relating to (1) communicable diseases such as hepatitis and the human immunodeficiency virus (HIV); (2) substance abuse treatment records; and (3) all mental health treatment records.

The purpose for disclosure of these records is to allow SEICTF to evaluate my medical history and injuries in this claim and to administer benefits I may be eligible for under the SEICTF program. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original. This Authorization for Release of Health Information is valid for one year from the date of my signature.

I understand that I may revoke this authorization by sending a signed, written notice to SEICTF and to the healthcare provider(s) authorized to disclose my health information pursuant to this document. However, I also understand that any revocation will be effective only to the extent that action has not already been taken in reliance of this authorization.

By refusing to sign or revoking this authorization, I understand that SEICTF will be unable to provide benefits under this program as medical records are required.

_____ _____
Employee Signature Date

EMPLOYEE: Give completed copy to your supervisor immediately after receiving treatment.
****

TO BE COMPLETED BY SUPERVISOR

Employee Name: _____ S.S. # _____ - _____ -_____

Date of Injury: _____ Agency: _____ Division/Facility: _____

Description of Accident/Injury: _____

_____

Supervisor's Signature: _____ Date: _____

When completed by supervisor and physician – immediately fax or email to SEICTF at (334) 223-6170 or (888) 827-6753 or SEICTF@finance.alabama.gov
****

TO BE COMPLETED BY PHYSICIAN

Diagnosis: _____

Work Status: _____May return to full duty

_____Out of work for _____ days, then return to work with restrictions (see below)

_____May return to work with the following restrictions for _____ days:

Activity restrictions: _____

_____
Physician Name **(please print):** _____ RETURN APPOINTMENT DATE: _____

Physician Signature: _____ Date: _____
****

TO BE COMPLETED BY EMPLOYEE AFTER BEING SEEN BY PHYSICIAN
I understand and agree to the recommended activity restrictions and follow up instructions. I agree I will not perform any activities outside the limitations either at work or home.

Employee Signature: _____ Date: _____

Instructions for Submitting Claim for Payment

****

Physician's office:

1. Immediately Fax this form to SEICTF at (888) 827-6753 (toll-free) or (334) 223-6170 or email to SEICTF@finance.alabama.gov.
2. Give original to employee. Have employee take original back to the employer. Keep a copy in the employee's chart.
3. Claim filing:

   A. **For authorization and timely payment, office notes must be sent to SEICTF**:
   Fax to (888) 827-6753 (toll-free) or mail to SEICTF: P. O. Box 1390, Montgomery, AL 36102.

   B. **Send claim to:**
   (1) Please file electronically to Blue Cross Blue Shield (Group 32035) - Use the WRI prefix with the employee's social security number**. (Do not use the EIB number.)** Do not charge co-pays or deductibles.

****

Pharmacy:

Send claim to Blue Cross/Blue Shield of Alabama. All prescriptions must be filed electronically with BCBS by using the WRI prefix and the employee's social security number. **(Do not use the EIB number.) Please use BIN# 004915, group number 32035 and in the PCN field use WRI.** SEICTF does have a Formulary and some drug classes require prior approval before BCBS will approve the prescription under WRI. **Charges filed manually, or through third party billing companies, will not be reimbursed.** If you are unable to obtain approval or confirmation, please contact SEICTF at (800) 388-3406 for assistance.

****