CorVel Advocacy
Certified Workplace Medical Plan

Employee Rights and Responsibilities Information Sheet

Your employer has contracted with CorVel Corporation's Certified Workplace Medical Plan in Oklahoma called CorVel Advocacy. As an employee of a participating employer, there is no cost to you for our services or to treat with the CorVel network providers. This plan is only for work related injuries and will not affect your group or individual health plan.

CorVel Providers

CorVel Advocacy will provide access to convenient care for injured workers in Oklahoma. Convenient care, as defined by the Oklahoma State Department of Health, will be within a thirty (30) minute or less drive to a primary care delivery site, and sixty (60) minutes or less to a specialty service provider. CorVel Advocacy is able to serve a majority of Oklahomans with a network which includes over 150 facilities and more than 6,000 physicians.

How the CWMP works for you

CorVel Advocacy will provide you with access to medical treatment with physicians that are experienced in occupational medicine. Each medical provider must meet strict requirements and training in order to be a part of our network. Medical care is monitored by case management staff to ensure the treatment is appropriate and timely. Medical case management services are provided to help coordinate medical treatment and rehabilitation. These services are performed by registered nurses, licensed in the state of Oklahoma. CorVel Advocacy provides a dispute resolution process for concerns about medical treatment that has been received. There is also a grievance process for any issues with the CorVel Advocacy Plan.

Employee Rights and Responsibilities

- An injured Employee has the right, if the work-related injury is an emergency (life or limb threatening) to seek emergency medical treatment. If the injury is not an emergency, (life or limb threatening) the Employee must notify the Employer ***prior to*** seeking medical treatment. In the event of an emergency, the Employee is responsible for notifying CorVel Advocacy Case Management Department or Employer Designated Individual of any treatment received for a work-related injury within ***24 hours of the treatment*** by calling 800-496-3385.
- Employee must seek non emergency medical treatment from a network medical provider selected by the Employer. Treatment from an unauthorized medical provider may render the Employee responsible for payment of those medical services.
- During the course of an accepted injury, the Employee has the ***one time only*** right to apply for a change of physician within the network using the CorVel Advocacy Dispute Resolution Process.
- Employee has the right to file a verbal or written dispute relating to the medical care through the CorVel Advocacy Dispute Resolution Process.
- Employee will exhaust the CorVel Advocacy Dispute Resolution Process ***prior to*** seeking legal relief on an issue related to medical care.
- Employee has the right to file a verbal or written grievance related to the administration of the certified workplace medical plan through the CorVel Advocacy Grievance Process.

For questions about the CorVel Advocacy Certified Workplace Medical Plan, please call 800-496-3385 during normal business hours to speak to your medical case manager or contact your Employer Designated Individual.

CERTIFIED WORKPLACE MEDICAL PLAN
DISPUTE RESOLUTION PROCESS

The Dispute Resolution Process is available to any injured worker, employer, participating provider, or insurance carrier who may have an issue *relating to medical care.* The Dispute Resolution Procedure must be pursued and completed in accordance with TITLE 85A of the Oklahoma Statutes, Section 56. An individual must exhaust the Dispute Resolution Process prior to seeking remedy in the Oklahoma Workers' Compensation Commission.

When a Certified Workplace Medical Plan's office receives notice of a dispute, a resolution will be offered within ten (10) days. The ten-day time frame may be extended if necessary to gather further medical information relating to the dispute. If an extension is necessary, a written notice will be sent to all parties.

The Dispute Resolution Process consists of four (4) steps:

- ✓ **STEP 1:** A dispute resolution form is to be completed and received at the Certified Workplace Medical Plan's Office. Should the dispute be a denial of service, the injured worker, employer, participating provider, or insurance carrier, has forty-eight hours to inform CorVel of notice to appeal the decision.
- ✓ **STEP 2:** Upon receipt of a completed Dispute Form the Certified Workplace Medical Plan will attempt to resolve the dispute. If the issue can be resolved by CorVel, a final report will be sent to all applicable parties.
- ✓ **STEP 3:** If the Certified Workplace Medical Plan is unable to resolve the dispute, it will be referred to the Medical Director for settlement. If resolution is achieved, a final report will be submitted to all applicable parties.
- ✓ **STEP 4:** If the Medical Director feels additional expertise is required to resolve the matter, the dispute form and all available medical information pertaining to the issue, will be sent to either a specialist or a panel of health care providers per the Medical Director's discretion.

CERTIFIED WORKPLACE MEDICAL PLAN DISPUTE RESOLUTION FORM

Before you complete this form, have you contacted your plan by phone or fax, and discussed your complaint with a Certified Workplace Medical Plan representative? Some issues may be addressed without the need for formal Dispute Resolution.

This form is to be used by any Employee, Employer, Network Provider, Participating Physician or Insurance Carrier associated with CorVel's Certified Workplace Medical Plan, who has a complaint that *relates to medical care under the plan.* Complete all the requested information such as dates, names, and the specific resolution which you feel would remedy the situation. All available medical records will be reviewed. You will receive an answer within ten (10) days of the date the dispute is received, unless necessary information is not available in the normal course of business.

Person filing the dispute: Circle one of these choices:

(a) Employee (b) Employer (c) Network Provider (d) Participating Physician (e) Insurance Carrier

DISPUTE RESOLUTION FORM

EMPLOYEE INFORMATION: Please Print or Type:

Last Name: First Name: Middle Initial:
Daytime Phone No: (area code)

SSN#: Date of Injury:
Body Part:

Address: City:
State: Zip Code:

PROVIDER INFORMATION:

Name : Phone Number: (area code)

Address: City:
State: Zip Code:

EMPLOYER INFORMATION:

Name: Phone Number: (area code)

Address: City:
State: Zip Code:

INSURANCE CARRIER INFORMATION:

Name of Carrier: Phone number: (area code)

Address: City:
State: Zip Code:

- Briefly describe the situation that prompted this dispute. Provide dates, names, and any other pertinent facts that relate to the dispute. State what actions CorVel could take to remedy your dispute:

Signature **Date**

PRINTED NAME OF PERSON COMPLETING FORM **Date**