Patrick Hughes
Risk Manager
Michelle R. Kirby, CPA
Chief Financial Officer

Michael Jordan
Chief Administrative Officer
Ted Wheeler
Mayor

CITY OF PORTLAND
Office of Management and Finance
Risk Management
1120 SW 5th Avenue
Suite 1040-Risk
Portland, OR 97204

P: (503) 823-5101
F: (503) 823-6120
TTY: (503) 823-6868
portlandoregon.gov/brfs

November 15, 2022

Pashalle Johnson
8830 SE Flavel Apt 15
Portland, OR 97266

Claim Number: 2022-012951-10
Date of Injury: November 02, 2022
Injury: Multiple Body Parts

As you may know, City of Portland is self-insured for Workers' Compensation and, as such, we have received your claim for benefits.

Please list below the names of all health care providers (doctors, chiropractors, hospitals, clinics, etc.) who have treated you **prior to the above date of injury** for the **same or similar** type of injury or condition. In other words, where and with what doctor have you ever been treated before for the same type of injury or to the same body part.

Doctors, Hospitals, Chiropractors, Etc.	Address
1.	
2.	
3.	

If necessary, please use an additional sheet to list all providers.

☐ I have NOT had any treatment for this type of injury or to the same body part prior to this claim.

_____ _____
Signature Date

Please return this letter and the signed Medical Release form to me as soon as possible. If you have any questions, please call me, 503-823-5264.

Sincerely,
RISK MANAGEMENT SERVICES

Viki Bisby

Viki Bisby, AIC
viki.bisby@portlandoregon.gov
Senior Workers' Compensation Disability Analyst

BRFS BUREAU OF REVENUE AND FINANCIAL SERVICES

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Claim Number: 2022-012951-10
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RE: **IMPORTANT NOTICE OF ENROLLMENT IN MCO**. **PLEASE RESPOND**

Dear Pashalle Johnson:

We were sorry to hear of your recently reported injury. Your claim has been received and the number above has been assigned to your claim. We are temporarily placing your claim in a deferred status pending our investigation and receipt of information necessary to make an appropriate compensability decision. You will be contacted by your claims adjuster if further information is needed. **Oregon Law requires that workers submit to and fully cooperate with personal and telephonic interviews and other information gathering techniques, including the provision of medical records and attendance at insurer arranged medical examinations (IMEs).**

To date, we have not received your signed MCO election form that was included in your injured worker packet. As you know, from the information in your injured worker packet, ***YOU ARE REQUIRED TO CHOOSE AND BE SUBJECT TO THE PROVISIONS OF THE CITY OF PORTLAND'S MANAGED CARE ORGANIZATION (MCO) AND ONLY THOSE MEDICAL SERVICES WITHIN THE PROVISIONS OF THE MCO (EITHER KAISER-ON-THE-JOB, PROVIDENCE OR CAREMARK COMP) WILL BE COVERED UNDER THIS CLAIM.***

Enclosed with this letter is another MCO Election Form. Please mark your choice of MCO on the enclosed form and return to Risk Management. ***IF WE DO NOT RECEIVE YOUR SIGNED ELECTION WITHIN 10 WORKING DAYS FROM THE DATE OF THIS LETTER,*** we will make the choice for you and notify you of your enrollment. Once you become enrolled, ***YOU CANNOT CHANGE THE MCO***.

Please disregard if you have already submitted the MCO election form in the injured-workers packet.

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The above information is being provided to you in accordance with Oregon Workers' Compensation law. Please refer to the materials in your injured worker packet for additional information concerning your rights and responsibilities.

For further assistance or information, you may call your certified claims examiner at 503-823-5264 during regular business hours. We will make every effort to respond to your inquiry within 48 business hours.

Sincerely,
RISK MANAGEMENT SERVICES

Viki Bisby

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viki.bisby@portlandoregon.gov
Senior Workers' Compensation Disability Analyst

C: MCO

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MANAGED CARE ORGANIZATION (MCO) CHOICE FORM

Claimant: PASHALLE JOHNSON
Claim Number: 2022-012951-10
Date of Injury: 11/02/22

Health Record Number (if applicable): _____ Bureau/Division: _____

Once you become enrolled, your workers' compensation claim will be subject to the provisions of the City's Managed Care Organization Program, (MCO), and all care must be coordinated through the MCO. Please check a box below to select the MCO organization to provide you with the medical services for your workers' compensation claim.

ONCE YOU BECOME ENROLLED, YOU MAY NOT CHANGE MCOs.

I select: ☐ Caremark Comp MCO
(**NOTE: This is not the same as the City's group health plan.)**

I select: ☐ Kaiser On-The-Job
(NOTE: This is not the same as the City's group health plan.)

I select: ☐ Providence MCO
(NOTE: This is not the same as the City's group health plan.)

Signature: _____ Date: _____

Upon enrollment, you will be required to select an attending physician and other medical services within the MCO except in the following instances:

1. You may receive immediate emergency medical treatment from a medical provider who is not a member of the MCO, but you must be referred into the MCO panel for all subsequent treatment.

2. If you have an established, documented history of treatment with a primary care provider (an MD or DO who is a general practitioner, a family practitioner, an authorized nurse practitioner, or an internal medicine specialist), you may continue to receive your medical services from that provider if your doctor agrees to comply with all terms and conditions of the MCO regarding service delivery.

If you are going to treat with your primary care provider, please supply the following information:

Provider's Name: _____ Provider's Telephone Number _____

Provider's Address: _____
Street, City, State, Zip Code

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November 15, 2022

To: Bureau Safety Representative; Timekeeper; FMLA Coordinator
From: Risk Management Services, Workers' Compensation

Claimant: PASHALLE JOHNSON
Personnel Number: 1083375
Claim Number: 2022-012951-10
Date of Injury: 11/02/22
Waiting Period:

Please note the following:

_____ Worker has filed a worker's compensation claim. The claim is currently in deferred status pending investigation.

_____ Claim was set up using Form 801.

_____ Claim was set up using Form 827. **PLEASE SUBMIT FORM 801 ASAP**

_____ Worker's claim is now accepted. Please re-credit any sick leave, vacation leave or supplemental pay.

_____ Worker's claim has been denied. Worker has 60 days to appeal.

_____ Received claim of Aggravation of original injury. Claim has been re-opened.

_____ Aggravation claim has been accepted.

_____ Aggravation claim is denied.

_____ Worker's claim has been issued a Notice of Closure, Claimant is now medical stationary.

_____ Worker's claim is now closed.

_____ 3-Day Waiting Period paid by WC ( )

_____ Other: _____

Questions regarding time loss should be addressed to the timekeeper or Risk Management at 503-823-5101.

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