

Occupational Injury or Illness Report

This form contains sections to be completed by both the supervisor and the employee.

The accident should be investigated by the supervisor of the injured employee or department involved. It should be completed soon as possible to obtain the most accurate information.

Supervisor Section									
Date of Injury:			Date Reported:			Employer Name:			
Name of Employee:				S.S. No:		XXX-XX- (last four digits)			
Home Address, City, Zip Code:									
Home Phone:			Work Ext:		Date of Birth:				
Cell Phone:									
Sex:		Occupational Title:			Date of Employment:				
Time Work Shift Began:			Time Accident Occurred:			Day of week			
AM/PM			AM/PM			M T W TH F S SU			
Location:									
Injury Type (Circle)									
25	Foreign Body in Eye	81	Animal, Insect, Human Bite	28	Fracture				
43	Cut/Puncture	46	Hernia/ Rupture	02	Amputation				
40	Abrasion/Scratches	99	Heart Attack/Stroke	68	Skin Irritation/ Dermatitis				
10	Bruise/Contusion/Crushing	72	Hearing Impairment	07	Concussion/ Loss of Consciousness				
49	Sprain/Strain	66	Exposure (Chem. Temp. Elect)	24	Death				
04	Burn (Chem, Liquid, Electrical)	81	Exposure (Blood/ Body Fluid)	00	Other				
Injury Cause (Circle)									
46	Struck by/ Against Object	31	Noise	85	Animal, Insect, Human				
25	Fall-Same Level, Different Level	98	Repetitive Motion/Trauma	84	Hot Object, Substance or Fire				
54	Jumping or Climbing	30	Slipping/Tripping	26	Caught in/Under/ Between				
48	Vehicle Accident/ Struck by Vehicle	57	Pushing/Pulling/ Lifting/ Carrying	59	Other				
Was injury caused by another person, faulty/broken equipment, a vehicle?				Yes	No				
If yes, explain:									
Body Part Injured (Circle)									
02	Head/Neck/Face/Mouth	44	Wrist (Left Right)	74	Hips/ Buttocks				
05	Eye (Left Right)	45	Hand (Left Right)	46	Fingers (Left Right) Digit:				
04	Ear (Left Right)	61	Back (Upper Lower)	83	Knee (Left Right)				
48	Shoulder (Left Right)	67	Chest/Abdomen Including internal organs	85	Ankle (Left Right)				
41	Arm (Left Right)	66	Pelvis/ Groin	86	Foot (Left Right)				
42	Elbow (Left Right)	82	Leg (Thigh Calf)	87	Toes (Left Right) Digit:				
73	Respiratory	01	Other	96	No Physical Injury				
First Aid or Medical Treatment									
Was first aid given?			Yes	No	If yes, by whom:				
Was medical treatment required by a physician or hospital?					Yes	No			
Physician/ Hospital Name, Address, and telephone number:									

Explanation of injury (How, When, Where)

Date you first noticed the pain? _____ Did this pain develop gradually? _____ Or suddenly? _____

If the pain developed suddenly, exactly what were you doing when the pain was felt?

If nothing unusual or unexpected happened, what do you think caused the pain?

List body parts injured:

Have you discussed this pain with anyone at work? If yes, with whom and when? Yes No

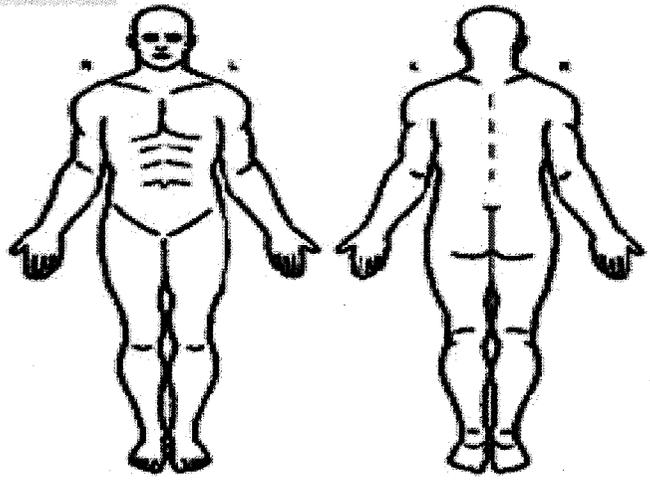
Have you had any recent non-work related injuries/illnesses? If yes, please list: Yes No

If the above answer is yes, what was the problem, when did it occur, and what (if any) medical treatment did you receive?

Show part(s) of the body injured, noting the longevity, type and degree of pain.

On the diagram below, indicate the location, description, and level of pain you are experiencing at this time.

Example: "A-6= Ache- Severe pain"



Note type of pain:

A = Ache	B = Burning	P = Pins & Needles
N = Numbness	S = Stabbing	O = Other

Note level of pain:

0	No Pain
1	Mild pain, you are aware of it, but it doesn't bother you
2	Moderate pain that requires medication to tolerate the pain
3	More severe pain
4	Severe pain
5	Intensely severe pain
6	Most sever pain, unbearable

Was medical treatment away from the job site offered?

Yes No

If treatment was offered, but declined, please sign:

Have you ever received medical treatment for the injured body part(s) listed above? If so, please note the date and physician/hospital where treatment was rendered. Yes No

Are you currently receiving Social Security **Disability** Payments (*not Social Security retirement payments*)? Yes No

Are you currently receiving Medicare assistance? Yes No

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief they are correct and complete.

Employee Name: (Print) _____
 Employee Signature: _____ Date: _____

Supervisor's Statement

As a result of your investigation, what do you believe occurred and why?

From your investigation is the validity of the accident in doubt? Yes No If yes, explain why.

Was a third party at fault? If yes, explain

Were there any witnesses? If yes, please list

Name	Address	Phone	Date

Supervisor's Signature: _____ Date: _____

MEDICAL CARE AUTHORIZATION FORM

Approved First Responder Facility

After Hours

TO BE COMPLETED BY EMPLOYER

Employee name _____

Nature of Injury _____ Body Part(s) _____

Date of Injury _____ Time of Injury _____

Authorized Personnel Signature _____ Date: _____

Title _____

This form needs to go with injured worker to medical provider!

TO BE COMPLETED BY PHYSICIAN

Diagnosis _____

Treatment _____

Post accident drug screen performed? Yes/ No _____

O.K. to return to regular duty on _____

Return to see me on _____

O.K. to work light duty beginning _____

with the following limitations _____

(Note: It is the philosophy of this company to provide modified duty work when possible.)

Unable to return to work until _____

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are correct and complete.

Physician's signature _____ Date: _____

This authorization applies to initial evaluation only. Any subsequent treatment, diagnostics, DME's or referrals need to be preauthorized by Consolidated Benefits Resources.

Notice Prescriptions:

If prescriptions are appropriate, please give the patient a written prescription. Prepackaged prescriptions are not authorized.

PLEASE FORWARD THE COMPLETED ORIGINAL FORM AND YOUR BILL

Consolidated Benefits Resources, L.L.C.
Post Office Box 13770
Oklahoma City, Oklahoma 73113

405.848.3387 *telephone*
800. 822.5733 *toll free telephone*
405.840.4298 *facsimile*

800. 898.6465 *toll free facsimile*

I, _____ (Circle) Patient, Parent, Guardian, legal custodian of:

(NAME OF PATIENT) SSN: ____ - ____ - ____ DOB: ____ / ____ / ____

authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name of individual/company to receive PHI:

Name of individual/company to disclose PHI:

Workers' Compensation Claims
Consolidated Benefits Resources, LLC.
P.O. Box 13770
Oklahoma City, Oklahoma 73113

Information authorized for use or disclosure, or to be obtained:

- All medical information concerning this patient.
- Medical information of this patient compiled between the dates of _____ and _____.
- Only: _____

The information will be obtained, used and/or disclosed for the following purpose(s) only:

- Insurance Continued treatment Legal At the request of the patient or patient's representative
- Workers' Compensation Benefits Other (specify) _____

Date Authorization expires: _____ (if no date is selected, this Authorization will expire in one (1) year from the date signed below).

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation to Claims Manager of Consolidated Benefits Resources, LLC.
- I release the entities listed above, their agents and employee from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will be compensated by the recipient for the disclosure, except for the cost of copying and mailing as permitted by law.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse confidentiality requirements.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

The information I authorize for release may include records which may indicate the presence of a communicable or noncommunicable disease, or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). I further understand that my medical information may indicate that I have been treated for psychological or psychiatric conditions or substance abuse.

Signature of Patient or Representative Date

Employer

Representative's Relation to Patient

Employer Address

Signature of Witness Date

Date Authorization expires

Notice of Rights: Information in your medical records that you have or may have a communicable or noncommunicable disease or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have risk exposures, disclosure pursuant to order of a court or the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, or by an order of a court or the Department of Health.

Mandatory Medicare Reporting Requirement

***** Please complete this form with each report of injury*****

Medicare now requires mandatory reporting of Workers' Compensation claims. The purpose of the reporting process is to enable Centers for Medicare & Medicaid Services (CMS) to correctly pay for the health insurance of Medicare beneficiaries by determining primary versus secondary payer.

To be completed by the employee (Please print)

Date: _____

Injured Worker Name: _____
(Name as it appears on your social security card)

Social Security Number: XXX-XX- _ _ _ _

Dear Injured Worker, please provide an answer to the following questions:

YES NO

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Are you currently on SSDI? (Social Security Disability)
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever applied for SSDI?
<input type="checkbox"/>	<input type="checkbox"/>	Do you anticipate filing for SSDI within the next 30 months?
<input type="checkbox"/>	<input type="checkbox"/>	Are you a Medicare beneficiary?
<input type="checkbox"/>	<input type="checkbox"/>	Have you are you currently participating in a Medicare Advantage Plan?
<input type="checkbox"/>	<input type="checkbox"/>	Do you anticipate filing for Medicare benefits in the next 30 month?

Signature of Injured Worker

Date

PLEASE FORWARD THE COMPLETED FORM TO:

CONSOLIDATED BENEFITS RESOURCES, L.L.C.
Post Office Box 581630
Tulsa, Oklahoma 74158-1630
918.594.5170 *telephone*
800.826.0419 *toll free telephone*
918.594.5171 *facsimile*
888.594.5171 *toll free facsimile*

Healthsystems Injured Worker Prescription Fill Form

Instructions for: Injured Workers

Please complete this form.

*Last Name, First Name:	*Social Security Number:
*Date of Injury:	*Date of Birth:
*Employer Name: <i>City of Yukon</i>	

*CONTACT: Tonia Wilson, Risk Manager
405/354-1895 for questions*

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

- Present this form to the Pharmacy.
- Locate a participating pharmacy closest to you. For assistance use the following tools:
 - A sample listing of pharmacies are provided at the bottom of this form
 - Visit: www.healthsystems.com and click on "Pharmacy Search" located under the "Pharmacy Tools button"

Instructions for: Pharmacists

Your pharmacy has contracted to participate in the Healthsystems Pharmacy Network. To dispense the patient's workers' compensation prescription:

- Call the Healthsystems Customer Service Center: 1.800.758.5779
- Process using the Member ID # provided by Healthsystems

Prescription Processing Information:

Transmit prescription using the following

Healthsystems Customer Service Center phone number:

1.800.758.5779 (press 1 for retail pharmacy option)

BIN:	Carrier/Customer ID:	* Member ID: <i>(provided by Healthsystems)</i>
012874	Consolidated Benefits Resources/6000CBRS	

Sample Healthsystems Pharmacy Network

Most local pharmacies in Oklahoma are in the HES network

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

Bi-Lo Pharmacy	Homeland Pharmacy	Medicine Shoppe	Rite Aid	Walgreens
Buy For Less Pharmacy	Hutton Pharmacy, Inc	Pharmacy Solutions, LLC	Sam's Club	Wal-Mart
Costco Pharmacy	Kmart	Pharmcare OK Inc	Spoon Drugs Inc	Winn Dixie Pharmacy
CVS Pharmacy	Lassiter Drug	Pyramid Pharmacy	T M Pharmacy Inc	Western Oaks Pharmacy
Drug Warehouse	Mays	Ralphs Pharmacy	Target	Westview Pharmacy
Fountain Park Pharmacy	Med-X Drug	Reasons Pharmacy	The Apothecary	
Harrison Discount Drug	Medicap Pharmacy	Reaxall Drug	Tyler Drug	