NORTHEASTERN
STATE UNIVERSITY

CLAIM FORMS TO USE WHEN A WORKPLACE INJURY OCCURS

Forms to be completed and submitted to HR for ALL on-the-job injuries:

REPORT OF OCCUPATIONAL INJURY OR ILLNESS – ***To be completed by the supervisor/manager and the employee on the day of the injury occurs.***

(This form must be completed to document an incident regardless of whether or not medical treatment is required. The notation just below the diagram on the form must be marked and signed if initial treatment is declined by the employee. Please note that if an employee initially declines treatment, this does **not** mean that they are waiving the right to request treatment at a later date.)

WITNESS/CO-WORKER STATEMENT – ***To be completed by any witnesses on the day of the incident.*** This form is most useful for serious injuries to document the incident or anyone who may have been involved.

Forms to be completed and submitted to HR for injuries requiring medical treatment and/or time off work:

MEDICAL CARE AUTHORIZATION FORM – ***To be completed by the supervisor or department head or a representative of HR.*** To be used when the injured worker needs medical treatment away from the work site. If immediate medical attention is required, the supervisor may complete the top portion of the form and send it with the injured worker to the medical provider. Where immediate treatment is not required, Human Resources will complete the form and refer the employee to a designated provider. Wherever possible, treatment for on the job injuries should be given within three days of the incident. A copy of any paperwork received by the employee after treatment should be returned to HR. *Employees should contact HR if a prescription is ordered. A "First Fill" form will be provided, authorizing the pharmacy to dispense up to a 10-day supply of medications if prescribed by the workers' compensation doctor.*

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION – ***To be completed by the employee on the day of the incident or as soon as possible thereafter.*** This form must be completed and signed by the employee in the event that the injury is turned in to our Workers Comp management organization. It allows them to obtain the medical documentation needed to process a claim for benefits.

MEDICARE SSDI QUESTIONNAIRE - This form provides information in order for CBR to correctly report required claims to Medicare. All injured employees should complete and sign.

WORKERS' COMPENSATION SICK/ANNUAL ACCRUED LEAVE ELECTION FORM – ***To be completed by the employee on the day of the incident or as soon as possible thereafter.*** Employees may elect to use earned leave balances to augment workers' compensation benefits as allowed by law. This form advises the University of the employees' wishes in this regard, and authorizes the use of earned leave to supplement TTD payments.

The State of Oklahoma requires additional notification to be completed by the employer and submitted to the Workers' Compensation Courts. In order to ensure that NSU is able to meet this requirement, we ask that ALL COMPLETED FORMS BE TURNED IN TO HUMAN RESOURCES AS SOON AS POSSIBLE AFTER AN INJURY OCCURS, *within 24 hours whenever possible*. HR WILL FORWARD MATERIALS TO CBR, OUR THIRD PARTY ADMINISTRATOR.

CALM

WITNESS/CO-WORKERS STATEMENT

I, _____ was present at the time that employee
(Witness name)

_____ Was reported to have received an on-the-job injury.
(Injured employee)

I did _____ did not _____ witness the injury that occurred.

The following is a brief description of what I observed on _____ at
(Date)

approximately _____ a.m. _____ p.m. _____.
(Time)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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.

_____ _____
Witness **Date**

_____
EMPLOYER

SEND ORIGINAL 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*

RETAIN COPY FOR YOUR FILE

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Consent for Release of Protected Health Information CALM

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

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

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:

Workers' Compensation Claims
Consolidated Benefits Resources, LLC.
P.O. Box 581630
Tulsa, Oklahoma 74158-1630

Name of individual/company to disclose PHI:

_____

_____

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.

A COPY IS AUTHORIZED AS AN ORIGINAL

CALM

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	
		Are you currently on SSDI? (Social Security Disability)
		Have you ever applied for SSDI?
		Do you anticipate filing for SSDI within the next 30 months?
		Are you a Medicare beneficiary?
		Have you or are you currently participating in a Medicare Advantage Plan? (This is a Medicare supplement product purchased from a private carrier such as Humana, Blue Cross Blue Shield etc.)
		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*

CALM

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: AM/PM		Time Accident Occurred: AM/PM		Day of week 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:				

Employee's Statement	**Employer:**		**Page 2**

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:

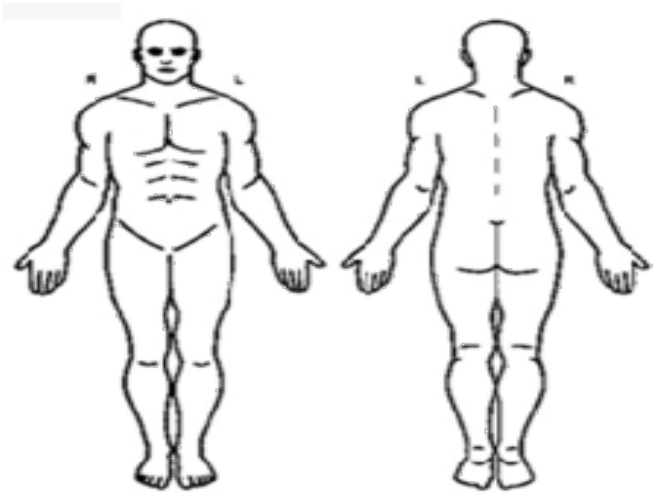
Have you discussed this pain with anyone at work? If yes, with whom and when? Yes No

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 die 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:**	

Workers' Compensation-Sick/Annual Accrued Leave Election Form

The University/college shall provide the benefits established under the Workers' Compensation Code to all University/college employees who are injured in on-the-job accidents. All regular employees who are injured in on-the-job accidents shall receive statutory benefits including medical expenses, temporary compensation and benefits for permanent disability or death and are allowed to make an election to supplement their temporary compensation.

I suffered an on-the-job injury on (month, day, year) , while working for the University/college. As a result of the injury, I acknowledge that I am entitled to receive temporary disability compensation according to the Workers' Compensation Code of Oklahoma. I further understand that I am entitled to receive such compensation for a period of time as may be provided for by law. I have accumulated certain sick leave/personal leave benefits, because of my employment, which are available to me when I am unable to work because of illness or injury.

Place an "X" in the appropriate option(s) below

Mark One: ☐ Certified ☐ Support Personnel

1. ☐ I am electing to have my workers' compensation benefits supplemented by deducting a pro-rated portion from my accrued sick/personal leave time.

   Number of days (To be filled in by a Human Resources representative)

   I understand that by choosing to be paid my accrued sick leave/personal leave in addition to the temporary disability provided by law, I will be paid my sick leave/personal leave on a pro-rated basis to the extent that I will receive my full wages until I return to work or the number of sick leave/personal leave days I have are exhausted. I understand that after the number of specified sick leave/personal leave days are exhausted, I will receive temporary disability compensation for a period of time as may be provided for by law. I understand that my accrued sick leave/personal leave benefits will be decreased on a prorated basis by those days I use as a result of making this election.

2. ☐ I am electing to be paid for the waiting period by deducting _____ days from my sick/personal accrued leave time.

   Under the Workers' Compensation Code, temporary benefits begin the fourth day off work due to an on-the-job injury. The first seven calendar days are considered a waiting period during which time temporary benefits are not paid, but I request that I be paid my accrued but unused sick leave/personal leave to cover _____ days.

(Note: if you are electing to be paid a supplement to your weekly workers' compensation benefits; and also to be paid for the waiting period, you must mark your election to both numbers 1 & 2.)

3. ☐ I do not authorize the use any of my accrued sick leave/personal leave benefits while I am off work due to my on-the-job injury. I will be paid only the Workers' Compensation benefits allowed by law.

Name _____ Social Security # _____
Last First Middle

Address _____
Number and Street City State Zip Code

University/college: _____ Department_____ Job Title_____

_____ _____
Signature of Employee Date

Witness:_____
University/college Representative

Healthesystems Injured Worker First Fill Prescription Form

Instructions for: Employer*

Please complete this form before providing to Injured Worker.

*Last Name, First Name:	*Social Security Number:
*Date of Injury:	*Date of Birth:
*Employer Name: Northeastern State University	

*Required Information

Instructions for: Injured Workers*

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

1. Present this form within 15 days of the date you were injured.
2. Locate a participating pharmacy closest to you. For assistance use the following tools:
   - Call: 1.800.758.5779
   - Visit: www.healthesystems.com and click on "Pharmacy Search" located under the "Pharmacy Tools button"
   - A sample listing of pharmacies are provided at the bottom of *this form*

**For new injuries only*

Instructions for: Pharmacists

Your pharmacy has contracted to participate in the Healthesystems Pharmacy Network. To dispense the patient's first-fill for their workers' compensation prescription:

- Indicate that this is a new workers' comp injury; do not process under an existing injury
- Call the Healthesystems Customer Service Center: 1.800.758.5779
- Process using the Member ID # provided by Healthesystems

Prescription Processing Information:
Transmit prescription using the following

Healthesystems Customer Service Center phone number: **1.800.758.5779** (press 1 for retail pharmacy option)		
BIN: **012874**	Carrier/Customer ID: ***Consolidated Benefits Resources/6000CBRS***	* Member ID: *(provided by Healthesystems CSC representative)*

*Required Information

Healthesystems Pharmacy Network

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

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

The injured Worker, in many states, has the free, full and absolute choice in the selection of a pharmacy or pharmacist. The above information is provided if the injured worker needs assistance in locating a pharmacy.