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:				
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:				

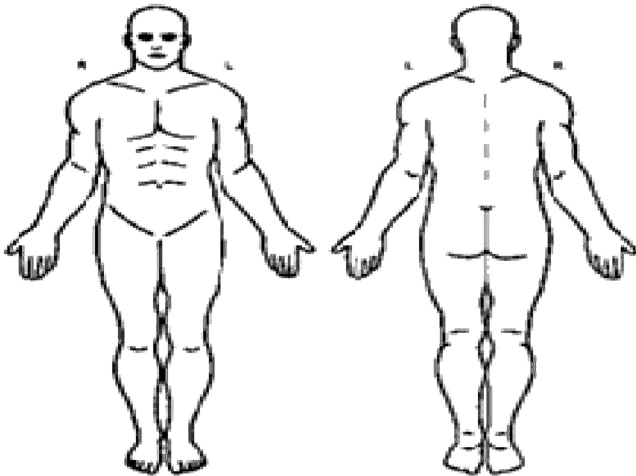
Employee's Statement

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:

Level	Description
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:**	

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**

City of Yukon
____
EMPLOYER

SEND ORIGINAL TO:

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*

RETAIN COPY FOR YOUR FILE

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

MEDICAL CARE AUTHORIZATION FORM

Approved First Responder Facility	After Hours
McBride Occupational Health 4901 W. Reno Suite 500 Okc, OK 73127 Phone # 405/230-9250	Emergency Room

TO BE COMPLETED BY EMPLOYER

Employee name____

Nature of Injury ____________________Body Part(s)______________________

Date of Injury_________________________ Time of Injury__________________

Authorized Personnel Signature_______________________Date:_____________

Title ____________________________

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*

Consent for Release of Protected Health Information **OMAG**

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 13770
Oklahoma City, Oklahoma 73113

Name of individual/company to disclose PHI:

City of Yukon
____

____

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

*Injured Worker First Fill Prescription Form**

To be filled out by employer and given to injured worker

Please **PRINT** the following information: (*Required Fields)

Last Name:	First Name:	Date of Birth:
***Social Security Number:** **XXX-XX- (last four digits)**	***Date of Injury:**	Type of Injury:
Employer's Name:	Employer's Phone #:	Body Part Injured:
*Employer's Signature Authorizing Prescription: Tonia Wilson, Risk Manager Cell #405-370-3578		Date:

Injured Worker Instructions: (*For New Injuries Only)

Present this form to the Pharmacy; No co-pay will be required.

- On your first visit to a network pharmacy, please give this form and written prescription to the pharmacist to expedite the processing of your approved Workers' Compensation prescriptions.
- Approved prescriptions are based on the parameters established by **Consolidated Benefits Resources**. Please contact your pharmacy for refills.
- If your local Pharmacy is not listed below, please call 1-800-758-5779 to locate a participating pharmacy near you or go to www.healthesystems.com.

Sample of Healthesystems Network Pharmacies

Albertsons	CVS	Indian Health Center	Med-X Drug	Sooner Pharmacy
Apothecary Shoppe	Dons	Kens	NCS Healthcare of OK	Target
Buy for Less	Drug Mart	Kmart	Palace Drug	United Supermarkets
Central Drug	Drug Warehouse	Mays Drug Store	Pratts Pharmacy	United Discount Drug
City Market	Eckerd	Medical Center Phar	Professional Pharmacy	Walgreens XXXX
Clinic Pharmacy	Family Meds	Medicap Pharmacy	R&S Drug	Wal-Mart
Couch Pharmacy	Homeland	Medicine Chest	Reasors Pharmacy	Western Drug
Crest Discount Phar	IHS	Medicine Shoppe	Sam's Club	Winn Dixie

Pharmacist Instructions:

Your company has a contract to participate in the Healthesystems Pharmacy Network.

- **To dispense the patient's "First-Fill", please call Healthesystems at 1-800-758-5779.**
- **Please indicate to the Healthesystems Help Desk this is a new injury.** *Please do not process under an existing injury.* Thank you for your assistance.

BIN# 012874

Healthesystems™

Temporary Member ID (Pharmacist Use Only)

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?
		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 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*