

## **Workers' Compensation "On the Job Injuries" Supervisor/Employee Instructions**

An employee **injured on the job to any extent should report immediately** to his/her supervisor. The **supervisor** is to immediately **call Human Resources** (if after 5:00 p.m. HR should be notified the following day) and inform them of the nature of the injury and receive further instructions. Failure to notify Human Resources could result in the Workers' Compensation claim being denied.

SE's first responder is the Urgent Care Clinic, 1807 University Blvd, Durant (580) 920-2273 (after hours-use the Medical Center of Southeastern Oklahoma Emergency Room 580-924-3080). Using a physician other than the first responder is considered unauthorized treatment and could result in non-payment of the claim.

**In cases of serious injuries**, contact the campus police office (extension 2911) and the student health services office (extension 2867) immediately. Also, if injuries are serious, the employee should be transported by ambulance to the nearest available emergency health care treatment center.

In cases of **injuries incurred after 5:00 p.m.**, contact campus police office (extension 2911 or non-emergency 2727) who will in turn assess the situation and respond accordingly. This may include calling the ambulance service, fire department rescue unit, etc.

### **INJURIES OTHER THAN SERIOUS INJURIES:**

1. **Offer medical attention** - If ambulance was not necessary but medical attention is needed complete the following forms:

**Medical Care Authorization** – This form is completed by the supervisor and taken with the employee to the First Responder, Urgent Care Clinic of Durant (1807 University Blvd., Durant, phone 580.920.2273)

**Injured Worker First Fill Prescription Form** – This form is completed by the employer and sent with the worker when they go to the doctor. This provides authorization to dispense up to a 10-day supply of medications if prescribed by the workers' compensation First Responder.

**Witness/Co-Workers Statement** – Supervisor is to see that all witnesses to the accident complete this form and return to Human Resources as soon as possible whether or not the employee receives medical treatment.

**Occupational Injury or Illness Report** – This form is completed by both the supervisor and employee on the day of the injury and returned to Human Resources as soon as possible. This form can be used to document an incident regardless of whether medical treatment is required.

**Consent for Release of Protected Health Information** – This form speeds up the payment of medical bills and is required for CBR to obtain medical records. It is signed at the bottom by the injured worker. *Signature of injured worker is required on this form.*

**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 this form.

**Sick/Annual Leave Election form** – This form should be completed by the employee and the employer. It allows the opportunity for the injured worker to supplement their workers' compensation benefits by using a pro-rated portion of their accrued sick/annual leave time.

2. **Before the employee returns to work, the employee should bring the doctor's release to Human Resources.**
3. **If the employee does not seek medical attention** at the time of the accident and medical attention is needed later the employee should come to Human Resources.

Per Oklahoma State Statutes and Consolidated Benefits **an employee can no longer seek medical treatment from their personal physician.** (\*See State Statute below)

\*Oklahoma Statutes Citationized  
Title 84. Workers' Compensation  
Chapter 2  
Section 14 – Medical Attention  
Letter B

“The employer’s selected physician shall have the right and responsibility to treat the injured employee. A report of such examination shall be furnished to the employer and the injured employee within seven (7) days after such examination.”

**Supervisors: Please consider appointing someone in your office the authority to complete and sign needed paperwork in your absence. This will help with the delay of any treatment needed.**

# CALM

## 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 \_\_\_\_\_

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### 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, or referrals need to be preauthorized by Consolidated Benefits Resources.

### **Notice Prescriptions:**

If prescriptions are appropriate, please give the patient a written prescription. All prescriptions should be filled at the Store pharmacy at no cost or co pay to the employee.

### **PLEASE FORWARD THE COMPLETED ORIGINAL FORM AND YOUR BILL**

Consolidated Benefits Resources, L.L.C.

P.O. Box 581630

Tulsa, OK 74158-1630

(918) 594-5170

(800) 826-0419 (toll free)

(918) 594-5171 (fax) (888) 594-5171 (toll free fax)



# CALM

## **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:		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.healthsystems.com](http://www.healthsystems.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
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

# 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)**

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*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.*

# 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**

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

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*

# Consent for Release of Protected Health Information **CALM**

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 581630  
Tulsa, Oklahoma 74158-1630

\_\_\_\_\_  
\_\_\_\_\_

**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

## 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:	ZZZ/ZZ/*****rcu'hqt'f ki ku+				
Home Address:										
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

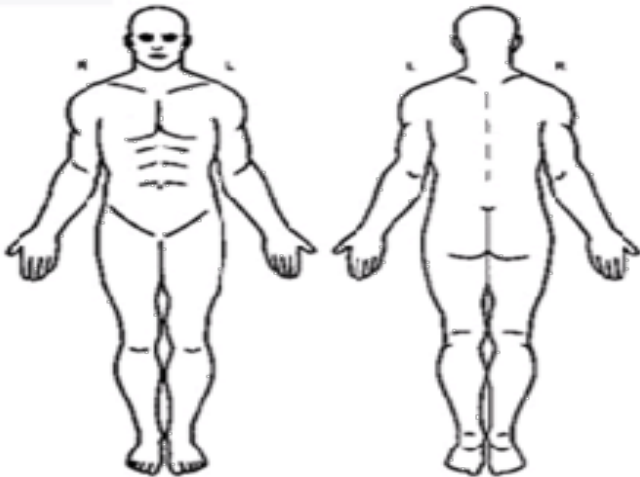
Have you had any recent non-work related injuries/illnesses? If yes, please list:      Yes      No

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"



<b>Note type of pain:</b>		
<b>A</b> = Ache	<b>B</b> = Burning	<b>P</b> = Pins & Needles
<b>N</b> = Numbness	<b>S</b> = Stabbing	<b>O</b> = Other
<b>Note level of pain:</b>		
<b>0</b>	No Pain	
<b>1</b>	Mild pain, you are aware of it, but it doesn't bother you	
<b>2</b>	Moderate pain that requires medication to tolerate the pain	
<b>3</b>	More severe pain	
<b>4</b>	Severe pain	
<b>5</b>	Intensely severe pain	
<b>6</b>	Most severe pain, unbearable	
<b>Was medical treatment away from the job site offered?</b>		
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 <b>Disability</b> Payments ( <i>not Social Security retirement payments</i> )?	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 Oklahoma Workers' Compensation Act 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 laws 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 7 days of wages from my sick/personal accrued leave time.

Under the Workers' Compensation Act, temporary benefits begin the eighth day off work due to an on-the-job injury. The first seven 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 these seven days.

**(Note: if you are electing to be paid a supplement to your weekly workers' compensation benefits; and also to be paid for the 7-day 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