MEDICAL CARE AUTHORIZATION FORM

Approved First Responder Facility

Urgent Care Durant (Texomacare)
1807 West University Blvd.
Durant, OK 74701
Phone: 580-920-2273
Fax: 580-920-9978

After Hours

AllianceHealth Durant
Emergency Room
1800 West University Blvd.
Durant, OK 74701
Phone: 580-924-3080

TO BE COMPLETED BY EMPLOYER

Employee Name _____

Nature of Injury _____ Body Part(s) _____

Date of Injury _____ Time of Injury _____

Authorized Personnel Signature _____ Date: _____

Title: _____ Employer: _____

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
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*

Healthesystems Injured Worker First Fill Prescription Form

Instructions for: Employer*

Please complete this form before providing to Injured Worker.

*Last Name, First Name:	
*Date of Injury:	*Date of Birth:
*Employer Name:	

*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.

Consent for Release of Protected Health Information

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

_____ **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
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.
- 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

Occupational Injury or Illness **Supervisor** Report

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.

Date of Injury:	Date Reported:	Employer Name:
Name of Employee:	Occupational Title:	
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)

Foreign Body in Eye	Animal, Insect, Human Bite	Fracture	Burn (Chem, Liquid, Electrical)
Cut/Puncture	Hernia/ Rupture	Amputation	Exposure (Blood/ Body Fluid)
Abrasion/Scratches	Heart Attack/Stroke	Sprain/Strain	Skin Irritation/ Dermatitis
Bruise/Contusion/Crushing	Hearing Impairment	Death	Other
Concussion/ Loss of	Exposure (Chem. Temp. Elect)		

Injury Cause (Circle)

Struck by/ Against Object	Caught in/Under/ Between	Jumping or Climbing	Animal, Insect, Human
Fall-Same Level, Different Level	Pushing/Pulling/ Lifting/ Carrying	Noise	Repetitive Motion/Trauma
Hot Object, Substance or Fire	Vehicle Accident/ Struck by Vehicle	Slipping/Tripping	Other

Was injury caused by another person, faulty/broken equipment, a vehicle?	Yes	No	

If yes, explain:

Body Part Injured (Circle)

Head/Neck/Face/Mouth	Wrist L / R	Hips/ Buttocks	Arm L / R	Elbow L / R
Eye L / R	Hand L / R	Fingers L / R Digit:	Pelvis/ Groin	Shoulder L / R
Ear L / R	Back (Upper Lower)	Knee L / R	Ankle L / R	Foot L / R
Leg (Thigh Calf)	Toes L / R Digit:	Respiratory	Other	No Physical Injury

Chest/Abdomen Including internal organs

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/ Hosp Name, Address, and telephone number:

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 and have witness complete attached form

Name	**Address**	**Phone**	**Date**

Supervisor's Signature:	**Date:**

WITNESS/CO-WORKERS STATEMENT

I, _____ was present at the time that employee

_____was reported to have received an on-the-job injury.

I did_____ did not_____ witness the injury that occurred.

The following is a brief description of what I observed on _____ at approximately_____ a.m./p.m.

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

_____

Witness Date

_____

Employer

Send Original To:
CONSOLIDATED BENEFITS RESOURCES
Post Office Box 581630
Tulsa, Oklahoma 74158-1630
918.594.5170 *telephone*
918.594.5171 *facsimile*

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

Occupational Injury or Illness **Employee** Report

It should be completed soon as possible to obtain the most accurate information.

Employee Name:	Employer:
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:

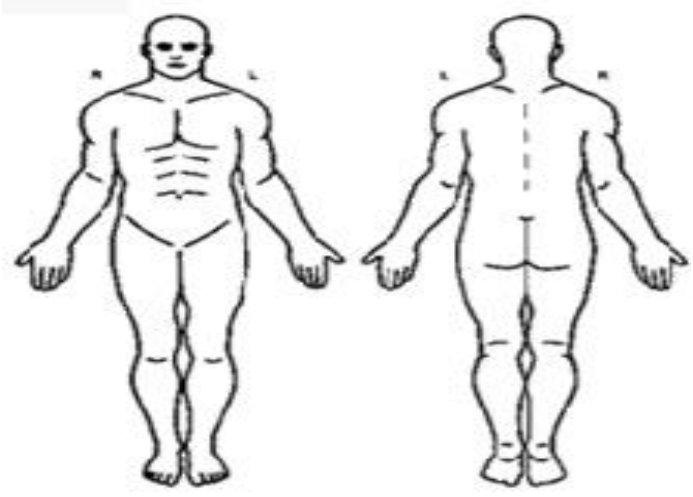
Have you discussed this pain with anyone at work? If yes, with whom and when? Yes No

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
2	Moderate pain that requires medication to tolerate the
3	More severe pain
4	Severe pain
5	Intensely severe pain
6	Most severe 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	

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): **Date of Birth:**

Employee Signature: **Date:**

Mandatory Medicare Reporting/Child Support Lien 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)

Date of Birth_____

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.) **If so, name of Carrier: _____**
		Do you anticipate filing for Medicare benefits in the next 30 months?
		If you are on Medicare, What is your Medicare Beneficiary Identifier Number (MBI)?_____
		Are you in End Stage Renal Disease?
		Do you have a Child Support Lien against you? If so, Which State?_____

Signature of Injured Worker Date

PLEASE FORWARD THE COMPLETED FORM TO:

CONSOLIDATED BENEFITS RESOURCES
Post Office Box 581630
Tulsa, Oklahoma 74158-1630
918.594.5170 *telephone*
918.594.5171 *facsimile*

Workers' Compensation-Sick/Annual Accrued Leave Election Form

The Educational Institution shall provide the benefits established under the Workers' Compensation Code to all educational institution 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 educational institution. 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 of wages 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 three 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 these ____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 _____
Last First Middle

Address _____
Number and Street City State Zip Code

Institution: _____Department_____ Job Title_____

_____ _____
Signature of Employee Date

Witness: _____
Institution Representative