

CALM
MEDICAL CARE AUTHORIZATION FORM

Approved First Responder Facility	After Hours
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TO BE COMPLETED BY EMPLOYER

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 _____

<input type="checkbox"/>	O.K. to return to regular duty on	_____
<input type="checkbox"/>	Return to see me on	_____
<input type="checkbox"/>	O.K. to work light duty beginning	_____
<input type="checkbox"/>	with the following limitations	_____
<input type="checkbox"/>	Unable to return to work until	_____

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

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. If prescriptions are appropriate, please give the patient a written prescription.

PLEASE FORWARD THE COMPLETED ORIGINAL FORM AND YOUR BILL TO: 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)

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



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:	*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.

Sample of Healthsystems 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 Healthsystems Pharmacy Network.

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

BIN# 012874



**Temporary Member ID
(Pharmacist Use Only)**

WORKERS' COMPENSATION COURT
 1915 NORTH STILES
 OKLAHOMA CITY, OKLAHOMA 73105-4918

EMPLOYER'S FIRST NOTICE OF INJURY

FORM 2

THIS SPACE FOR COURT USE ONLY

Send original to Workers' Compensation Court and 1 copy to Insurance Carrier

Please Type or Print. Enter all dates in MM/DD/YY format

Full Name of Claimant (Injured Employee) - LAST, FIRST, MIDDLE		Employee Email Address	
Complete Address	City	State	Zip
Telephone Number	Social Security Number		
Date of Birth	Sex	Length of Employment Years _____ Months _____	
Average Weekly Wage	Occupation (Job description)	Department	Was employment agreement made in Oklahoma? YES ___ NO ___

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (405) 522-8760 or in-state toll free (800) 522-8210.

Date of accident or last exposure	Time of accident or exposure _____ o'clock ___AM ___PM	Date Employer notified	Time workday began _____ o'clock ___AM ___PM
Last date employee worked	Has employee returned to work YES ___ NO ___ If yes, on what date _____	Did the employee die YES ___ NO ___ If yes, on what date _____	
OSHA Log Case #	Place of Accident or Occurrence State: _____ City: _____ County: _____		
Injury Resulted From: Single Incident _____ Cumulative Trauma _____	Does employee participate in a Certified Workplace Medical Plan? YES ___ NO ___ If yes, name of CWMP: _____		
Nature of Injury or Illness:	Is this accident/injury in question? YES ___ NO ___	Is subrogation involved? YES ___ NO ___ UNKOWN ___	
Describe activities when injury occurred with details of how event occurred. Include object or substance which directly injured the employee.			
Identify part(s) of body involved in injury or illness			
Full name and address of Treating Physician (please be complete)			
Employer's Own Risk Group: CompSource Oklahoma (CALM-FDG Workers Compensation Plan) Policy/SelfInsured Number: 01589337-10-010			
Name CONSOLIDATED BENEFITS RESOURCES, L.L.C.	Phone:	Fax:	
Address PO Box 581630, Tulsa, OK 74158	Policy Period - from 7/1/2010 to 6/30/2011		
Employer's Name and Complete Address CAMERON UNIVERSITY	Client: 926	Entity: 010	Location: CAMERON UNIVERSITY
Address:	Federal ID#:	Phone:	Fax:
	City:	State:	Zip:
Type of Business: College	NAICS Number:		
Type of Ownership: Private ___ State Gov't ___ County Gov't ___ Local Gov't <u>X</u>			

Upon filing this Notice of Injury, permission is given to the Administrator of the Workers' Compensation Court, the Insurance Commissioner, the Attorney General, a District Attorney or their designees to examine all records relating to the notice, any matter contained in the notice, and any matter relating to the notice.

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall promptly report in writing to the employer or insurance carrier any change in a material fact or the amount of income the employee is receiving or any change in the employee's employment status, occurring during the period of receipt of such benefits.

The undersigned hereby declares under penalty of perjury that he/she examined this notice and all statements contained herein are true, correct and complete, to the best of his/her knowledge. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

I hereby certify that this Form 2 as sent to the Workers' Compensation Court and a copy thereof to the insurer on the date described below:

Signed _____
 Signature of Preparer

By _____
 Name and Title of Preparer (Please Print)

Telephone Number _____
 Area Code and Number

Date _____

SUBMISSION OF THIS FORM IS NOT AN ADMISSION OF LIABILITY
 A Form 2 must be sent to the Workers' Compensation Court and to the Employer's Workers' Compensation Insurance Carrier within 10 days, or a reasonable time thereafter, of learning that an employee has suffered an accidental injury which results in lost time beyond the shift, or requires medical attention away from the work site, fatal or otherwise.

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:					
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:									

Explanation of injury (How, When, Where)

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

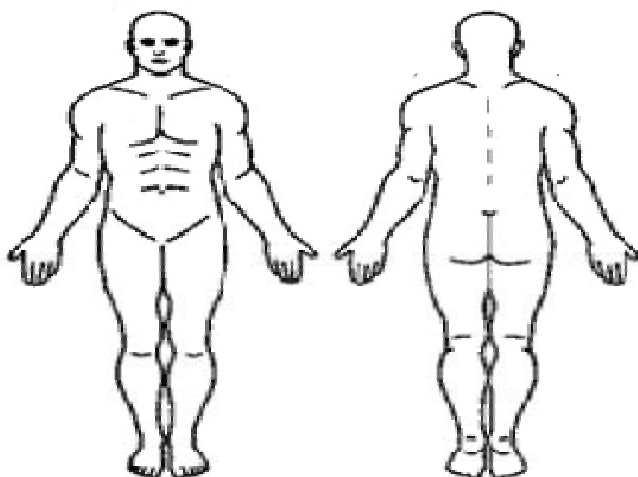
Have you had any recent non-work related injuries/illnesses? If yes, please list: Yes No

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 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	
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Are you currently receiving Social Security Disability Payments (<i>not Social Security retirement payments</i>)?	Yes	No	
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Are you currently receiving Medicare assistance?	Yes	No	
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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.

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.
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Was a third party at fault? If yes, explain

Were there any witnesses? If yes, please list

Name	Address	Phone	Date
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Supervisor's Signature: _____ **Date:** _____

Authorization for Disclosure of Protected Health Information

I, _____, authorize the disclosure of my protected health information as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, 2 subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information(as specified below):

Name(s): _____

Organization(s): _____

Address: _____

2. I authorize the following person(s) and/or organizations to receive my protected health information as disclosed by the person(s) and/or organizations(s) above.

**Consolidated Benefits Resources, L.L.C.
P.O. Box 581630, Tulsa, OK 74158-1630**

3. Specific description of the protected health information that I authorize for disclosure:
Treatment notes, diagnostic test results, history/physical notes, narrative reports, billing data.
4. Specific description of the purpose for each use or disclosure:
Workers' Compensation Benefits
5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.
6. I understand the information released may include information that may indicate the presence of communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the Human Immune Deficiency Virus also known as Acquired Immune Deficiency Syndrome ("AIDS").

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

Signed _____ Date _____

Name: _____

Employer: _____

Address: _____

Telephone: _____ Social Security No.: _____

Relationship or Authority of Personal Representative (if applicable)

This Authorization to disclose PHI constitutes a waiver of privilege per 76 O.S. §19. Photostatic copies of this Authorization carry the same authority as the original.

1 Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearing house with relates to: 1) the past, present or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or proves a reasonable basis to believe that the information can identify the individual.
45C.F.R.164.508

2 These laws apply to health plans, health care providers, and health care clearinghouses.

Explanation of the “Workers’ Compensation-Sick/Annual Accrued Leave Election Form

Title 85, known as the Workers’ Compensation Act allows any injured public university employee to receive up to 70% of their wage, not to exceed \$577/week. This is tax-free. For the majority of workers, the 70% TTD check approximates the employee’s normal take-home pay, so many elect option #3 on the form. This protects the full value of their accrued sick/annual leave.

The Act provides that a university employee must be allowed the opportunity to supplement their workers’ compensation benefits by using a pro-rated portion of their accrued sick/annual leave time. Unfortunately, the Act doesn’t define how to devise a pro-rated method to comply.

Your university can devise its own method, or possibly use one of the following methods that some universities currently utilize. It is also a good idea to obtain a written agreement from the worker indicating that if they do indeed make an election to supplement their pay, that the university is advised whether to deduct the pro-rated leave from the accrued sick leave or the accrued personal leave. The ACT doesn’t address a priority on this issue either.

1. Use a pro-rated formula of 1/3 day of accrued sick/personal leave for each day of TTD (Temporary Total Disability)
2. Keep the employee on full pay status, but obtain a separate written agreement between the employee and the university whereby the employee agrees to sign over any TTD checks back to the university. This method would still use the same 1/3 day of sick/personal leave for each day of TTD.

