WORKER'S COMPENSATION INFORMATION

Patient Name:____

Employer, **when Injured:**_______________________________________

WC carrier:____

WC claim #:____

Date of Injury:____

Body part(s) Injured:____

It would be helpful for you, as well as any medical provider you may see regarding this injury, ***for you to fill out, tear off, and carry with you the above slip***

ATTENTION WORKER'S COMPENSATION PATIENT

For your claim to be processed, Glendive Medical Center needs **you** to provide the following information. (In most cases GMC is not notified of this information by the insurer.) If you are unsure of the information, it should be available from your employer; except for the claim number:

1. Your name:____
2. Your Employer, **when injured:**

   PLEASE ATTACH YOUR EMPLOYER'S BUSINESS CARD HERE or provide their name, address and phone number

3. Work. Comp. carrier's name:____
4. Work. Comp. carrier's address:____

   ____
5. Your Work. Comp. claim number from the carrier: #______________________________
6. The original date of injury:____
7. Body part(s) injured:____

Please mail this information to our Work. Comp. Biller in the envelope provided, or call the Workman's compensation Biller at 406-345-3306 with this information within 10 business days ***or you will receive the bill for our services.***

A "First Report of Injury" needs filled out and given to your employer to start the workman's compensation claim process; if you have not already done so.

Keep a copy for your records.

OSHA Log Case #

First Report

Of Injury or Occupational Disease
Montana Department of Labor and Industry
PO Box 8011 Helena, MT 59604-8011

Adjuster Date Stamp

Worker

Last Name	First Name	M.I.	Date of Birth	Social Security Number

Mailing Address	City	State	Postal Code

Phone Number	Education	Gender	Marital Status	Number of Dependants
	☐ Less Than High School ☐ GED or High School Diploma ☐ Beyond High School	☐ Male ☐ Female ☐ Unknown	☐ Married ☐ Separated ☐ Widowed, Divorced, Single, Unmarried ☐ Unknown	

Wages

Date Hired	Gross earnings for FOUR pay periods preceding the injury
	Date/Amount / Date/Amount / Date/Amount / Date/Amount /

Employment Status	Number of days worked per week	Wage	Wage Period
☐ Full Time ☐ Part Time ☐ Seasonal ☐ Piece Worker ☐ Volunteer ☐ Other			☐ Hour ☐ Week ☐ month ☐ Day ☐ Bi-weekly

In addition to Gross earnings cited above worker received	Estimated value if any	Time Employee began work
☐ Room & Board ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other		

Worked next scheduled shift	Off work more than 4 work days	Date Last Worked	Date of Return to work	Full wages paid for date of Injury	Salary Continued
☐ Yes ☐ No	☐ Yes ☐ No ☐ Not Sure			☐ yes ☐ No	☐ Yes ☐ No

Accident Description

Job Title	Description of Accident

Cause of Injury	Cause Code	Part of Body	Part Code	Nature of Injury	Nature Code	Date of Injury	Time of Injury

Date disability began	Date of Death	Names of witnesses
		1) 2) 3)

Accident on employer's premises	Accident address or location
☐ Yes ☐ No	City State Postal code

Date employer notified	Accident Reported to	Safety equipment provided	Safety Equipment used
		☐ Yes ☐ No	☐ Yes ☐ No

Medical

Attending Physician's Name	Address	State	Postal Code	Phone number
Hospital name	**Address**	**State**	**Postal Code**	**Phone number**

Type of initial medical treatment received ☐ No Treatment ☐ Emergency room/Urgent Care ☐ Treatment on-site by employer or medical Staff ☐ Clinic/Dr. Office ☐ Hospital>24 Hours

Signature

"This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease, or death of the above named worker. I understand that signing this claim for compensation authorizes the release to the workers' compensation insurer (and its agents) and to the Montana Uninsured Employers' Fund of: Social Security records; rehabilitation records; and all health care information (medical records, pursuant to HIPAA, Public Law 104-191, 42 USC section 1301, et. seq., and section 39-71-604, MCA), that are directly relevant to the claimed injury, disease, or death. I also understand that if I obtain or exert unauthorized control over workers' compensation benefits to which I am not entitled, I may be prosecuted for theft."

Signature of Injured Worker or Beneficiary Date

Employer

Employer name	Doing Business as	Federal Employer Identification Number (Tax ID)

Mailing Address	City	State	Postal Code	Phone Number

Location of operation, if different from mailing address	Nature of Business NAICS Code	Self-Insured?
		☐ Yes ☐ No

Employer is a	Injured worker is a
☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company	☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ A member of the employer's (sole proprietor or partner) family living in the employer's household

Do you have any reason to question this accident? ☐ Yes ☐ No If yes, please explain fully. Use separate sheet if you need additional space	Was worker injured while in your employ ☐ yes ☐ no

Prepared By	Official Title	Phone Number	Date

Payroll Classification Code under which you report Employee's wages	Authorized Employer's Signature________________ Date__________

Insurer

Claim Administrator Claim Number	Date reported to Claim Administrator	The above information is correct with the following exceptions ☐ (Attach extra sheets if box at right is checked)

Claim Administrator's Name	Claim Administrator Address	Claim Administrator FEIN

Insurer Name	Insurer FEIN

Policy Number	Policy Effective date	Policy Expiration Date

First Report of Injury or Occupational Disease
Instructions

Workers' compensation insurance is a state-required insurance, which provides medical benefits, wage compensation and rehabilitation to workers injured on the job. Severe penalties can be assessed against an uninsured employer. Neither general liability nor health and accident insurance policies are substitutes for workers' compensation insurance.

The worker and employer may complete this form together or they may each submit a separate form.

Injured Worker's Instructions
Workers have two reporting requirements: 1) Notify your employer of an on-the-job injury within 30 days of its occurrence and 2) Complete this form as a claim for compensation. The form must be signed and submitted to the employer's insurer or the Department of Labor and Industry within 12 months of the accident. The form must be submitted for all injuries in order to protect your right to benefits in the event a seemingly minor injury develops into a more serious condition.

Complete a report of the injury
Be thorough in completing all areas except the gray shaded areas. It is important to you that we have complete information. You must provide your Social Security Number (SSN). This is a mandatory requirement that is permitted under Section 7(a) the Privacy Act of 1974 because the Montana Department of Labor and Industry's forms, prescribed by department rules in existence prior to January 1, 1975, have required disclosure of the SSN. The SSN is used as a key identifier of the claimant, and is needed because of the number of persons who have similar names and birth dates, and whose identities can only be distinguished by the SSN. Use extra sheets of paper if needed. Type or print with a ballpoint pen.

To ensure that workers' compensation systems will not be disrupted, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, 42 USC 1301, et. seq., **permits the disclosure of protected health care information pursuant to the provisions of state laws regarding workers' compensation.** 45 CFR 164.512(l) states:

> "Standard: Disclosures for workers' compensation: A covered entity may disclose protected health information **as authorized by and to the extent necessary to comply with laws relating to workers' compensation** or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault."

Employer's Instructions
Montana law requires employers to complete this form within six days after notice of every on-the-job accident, injury and/or occupational disease (OD) by a worker. Ensure all areas are completed except the gray shaded areas, which your insurer will complete. **It is important that we have complete information.**

Type or print with a ballpoint pen. If you are completing with WORD software, you may tab through the fields. If the injured worker is available to do so, they may file a claim for workers' compensation by completing and signing their portions of this form. You may then complete the employer section.

Send the original immediately to your workers' compensation insurer. If you don't know whom your insurer is, contact the Montana Department of Labor and Industry (see below). **SEND THIS FORM WITHIN THE 6-DAY LIMIT EVEN IF THE WORKER IS NOT AVAILABLE TO SIGN.** This form must be submitted even if the employer questions whether or not the reported injury and/or OD are job-related. Additional sheets of paper may be attached, if needed to fully explain all conditions concerning the injury and/or OD.

The United States Department of Labor, OSHA, requires employers to maintain a record of occupational injuries in the employer's office. Please copy the completed form for your records.

Insurer/Adjuster (not submitting electronically)
Please complete all gray shaded areas, and mail a completed copy immediately to the Montana Department of Labor and Industry at the address shown below. Boxes that have been **BOLDED** are mandatory in order to file this report. If you wish to file First Report information electronically, please contact the Employment Relations Division.

Further Information
Department of Labor & Industry
Employment Relations Division
Workers' Compensation Claims Assistance Bureau
PO Box 8011
Helena MT 59604-8011
(406) 444-6543
http://erd.dli.mt.gov

The United States Department of Labor, OSHA, requires employers to maintain a record of occupational injuries in the employer's office.