BI-1 01/06

Employees' and Physicians' Report of Injury

BrickStreet Use Only
Claim Number:
Team Assigned:
ICD9:

SECTION I - ALL INFORMATION MUST BE COMPLETED BY CLAIMANT

The receipt of a claim number does not entitle an employee to benefits under WV Workers' Compensation Law. In signing this form, I certify the statements and answers set forth are true and correct. I am aware the law provides for severe penalties if I knowingly provide a false statement or withhold a material fact or statement respecting any information requested by BrickStreet Insurance. **Initials of Injured Employee:** _____

1. Name: Last | First | MI
2. Social Security Number: | Marital Status:
3. Injury/Last Exposure Date: / / | Time: ☐ a.m. ☐ p.m.
4. Address:
   City: | County: | State: | Zip:
5. Telephone: ( ) | Sex: ☐ Male ☐ Female | Date of Birth: / /
6. Time You Began Work on Date of Injury: ☐ a.m. ☐ p.m.
7. Date Stopped Work for Injury: / / | Time: ☐ a.m. ☐ p.m.
8. Body Part(s) Injured:
9. How Did Injury Occur? *(Specify the cause, what you were doing, and equipment/objects involved)*:
10. Job Title/Description:
11. Did Injury Occur on Employer's Property? ☐ Yes ☐ No Address where injury occurred:
12. Employer Name and Address:
    City: | County: | State: | Zip:
    Telephone: ( ) | Supervisor's Name:
13. If Public Employee, Check One *(If County Board of Education employee, complete the County Board Option Form)*:
    ☐ Use Sick Leave ☐ Draw Temporary Total Disability Benefits

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge and belief. I am aware the law, specifically § 61-3-24f, provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I authorize any physician to release to or orally discuss with, either my employer or an authorized agent of BrickStreet Insurance, any medical records pertaining to the occupational injury or illness for which I am claiming benefits and any prior injury to or disease to the portion of my body for which I am alleging a medical impairment. I acknowledge the provisions of WV Code § 23-4-7 providing authorization for release of medical information by a physician to my employer or employer representative.

Employee's Signature: **Date:** / /

SECTION I - ALL INFORMATION MUST BE COMPLETED BY INITIAL PROVIDER

I have been informed of my responsibilities under WV Workers' Compensation Law and agree to abide by such in the administration of services provided by BrickStreet Insurance. I understand the submission of false statements or billing will result in the termination of my contract as well as prosecution under state and federal law.
Initials of Provider / Physician: _____

1. FEIN or SSN: | Name of Physician / Hospital:
2. Address: | Telephone: ( )
   City: | County: | State: | Zip:
3. Date you were first consulted for this condition? / / | Date Employee was / will be able to return to work: / /
4. Condition is a result of: ☐ Occupational Injury ☐ Occupational Disease ☐ Non-Occupational Condition
5. Disability Period: ☐ Less than 4 days ☐ 1 Week ☐ 2 Weeks ☐ 3 Weeks ☐ More than 4 Weeks
6. Can employee return to modified work? ☐ Yes ☐ No
7. Nature, Body Part and Type of Injury: | Diagnosis Code(s) (ICD9-CM) in Order of Severity:
   7a. Nature:
   7b. Body Part: | 7c. Type of Injury:
8. Did this injury aggravate a prior injury/disease? ☐ Yes ☐ No If Yes, Explain:
9. Name and address of physician referred to:
10. If claimant was hospitalized, where?

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law, specifically § 61-3-24g, provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge my contractual obligations to BrickStreet Insurance and agree to release any office notes / test results immediately to BrickStreet Insurance.

Physician's Signature: **Date:** / /

General Instructions for Completing the BI-1,
"Employees' and Physicians' Report of Injury"

- Please Read Carefully -

General Overview: The claim initiation process now involves the filing of two individual forms:
BI-1, Employees' and Physicians' Report of Injury: To be completed by the injured employee and the medical provider.
BI-3, Employers' Report of Injury: To be completed by the employer.

A claim cannot be established until BrickStreet Insurance has received at least one of the forms listed above. This form should not be used to file occupational pneumoconiosis or hearing loss claims.

Please note that W.V. Code 23-4-1 provides that employees of the state and its political subdivisions are ineligible to receive workers' compensation benefits while drawing sick leave benefits at the same time for the same reason. **You must make your choice known in Question 13 of this form.**

To the Claimant: Section I of this form must be completed by you. **When you have completed this form, make a copy for your records and make a copy to give to your employer.** The initial medical provider is responsible for completing Section II of this form, and your employer is responsible for completing the BI-3, Employers' Report of Injury. Both the provider and employer will be required to send the signed completed forms to BrickStreet Insurance. If you do not receive a decision on your claim within **14 days** after sending the form, contact BrickStreet Insurance. The responsibility of filing a claim rests with you. To be eligible for benefits**, your claim must be filed with BrickStreet Insurance within six months** from and after the injury or death. If you have any questions, you may contact BrickStreet at 1-866-45BRICK (1-866-452-7425) or visit our Web site at www.brickstreet.com.

To the Initial Medical Provider: Section II of this form must be completed by you. The timely provision of information regarding the claimant's condition is vital in deciding eligibility for benefits. Each answer should be as specific as possible. You should immediately send a copy of all records, office notes and test results regarding the claimant's exam to BrickStreet Insurance. **After completing this form, please make two copies – one for your records and one for the claimant to take to the employer. Your office is responsible for sending the signed original form to BrickStreet Insurance.** If you have any questions, you may contact BrickStreet Insurance at 1-866-45BRICK (1-866-452-7425) or visit our Web site at www.brickstreet.com.

Section I	
Question Number	**Explanation**
3.	This date is defined as either the date you were injured or the date you were last exposed if you are filing an occupational disease claim.
8.	List part(s) of body injured.
9.	Your description of how the injury occurred is reviewed to determine eligibility for benefits.
10.	Describe the job you are currently working. If you are a state, municipal or county employee, you need to include that in the information. (i.e. construction workers for the state.)
13.	According to BrickStreet Insurance's Temporary Total Disability Benefits/Sick Leave Policy, if you are absent from work due to a work-related injury, you must choose to receive either Temporary Total Disability benefits (TTD benefits) from BrickStreet Insurance or paid sick leave. If you elect to receive TTD benefits, you may use sick leave until you receive your initial TTD benefit check; however, this leave will be restored when you reimburse your employer the net value of the paid sick leave used, according to the provisions of this policy.
Section II	
Question Number	**Explanation**
1.	Federal Identification Number or Social Security Number and name, facility or group name you report to BrickStreet for billing purposes.
4	In your opinion, was the patient injured at work, exposed to a disease at work, or is the condition not work related?
7a.	Define injury. (i.e., sprain/strain, fracture, laceration)
7b.	Part(s) of body injured.
7c.	How injury occurred. (i.e., lifting, fall, motor vehicle accident)
8.	Describe in detail what effect, if any, the patient's previous health may have on this injury.

Return completed form to:

BrickStreet Mutual Insurance
P. O. Box 3151
Charleston, WV 25332-3151

When completing this form, enclose attachments if additional space is needed.