Dear OSAG Members,

Welcome to OSAG and CBR, this year we have made some changes to our claim packet. Attached you will find the Workers Compensation Claim Reporting Packet. Please distribute to the appropriate individual at your district. Also replace any old forms you may have with this packet.

Who is CBR? CBR is an Oklahoma based TPA firm maintaining a claims office in Oklahoma City and one in Tulsa. CBR has been in this business for forty (40) years here in Oklahoma and we have first-hand knowledge that they provide great service! Below is a short overview of what to expect:

1. **Team Approach to Claim Handling**- CBR employs 32 licensed claims adjusters. Four (4) are in management positions and the remainder work closely with each individual employer. A team approach is used to allow you to get to know your adjuster, but also to maintain a high degree of supervision. If your adjuster is out of the office, the supervisor can readily solve your needs.
2. **Medical Bill Review Reduction.** CBR reduces medical provider bills by an average of 56%. Coupled with a seamless PPO, CBR selects the best specialists for your workers to expedite medical care and a return to work.
3. **Pharmacy Plan -** CBR utilizes HealtheSystems' pharmacy benefit program. Teaming with HealtheSystems helps reduce the cost of prescriptions through participating pharmacy discounts; and simplifies the process for the injured worker. Obviously, the large pharmacy chains are in the network, but we believe you'll be pleasantly surprised that most local pharmacies are also in the plan.
4. **Claims Packets**- Included in this packet are several forms. CBR utilizes a variety of claim information forms to better serve you and the needs of your workers. Expediting medical care is crucial and your adjuster will work closely with you to assist a return-to-work strategy.
5. **Safety Seminars**- OSAG will conduct two ½ day safety training seminars during the year, so watch for a future announcement on the dates.

HOW TO REPORT WORK RELATED INJURIES TO CONSOLIDATED BENEFITS RESOURCES (CBR)

CLAIMS ARE MOST EFFECTIVELY RESOLVED WHEN REPORTED WITHIN 24 HOURS OF THE EMPLOYEES REPORT OF INJURY.

STEP 1

Once an injury has occurred, be certain to obtain appropriate medical care for your employee. Mail or fax a completed Form 2, the HIPPA Compliant Release Form, and any other completed forms to CBR. We understand that there may be a delay in completing all of the forms, but please fax the Form 2 ASAP and send the other forms once complete. Please encourage your supervisors to submit the claim within 24 hours of the accident.

STEP 2

After sending a Form 2 to CBR, forward any medical bills to CBR, or ask the medical provider to send their bills directly to CBR. Please do not send duplicate copies of your "Form 2" with the bills.
NOTE: Employees should be advised that any bills related to their on-the-job injury received at their home should be brought to you to be forwarded to CBR.

STEP 3

Keep in close contact with your injured employees regarding their treatment and off-work status. If they have questions that you cannot answer, they may call CBR directly. Please feel free to provide injured workers with our 800 number. Notify CBR if your injured employees miss work due to their doctor's orders, as well as when the employee returns to work.

STEP 4

Inform the injured worker that a CBR adjuster will be calling them to discuss the details and process their claim.

STEP 5

Report every claim and remember that an "employee" must be injured during the "course and scope of their employment." It is best to let your CBR adjuster determine compensability of the claim.

GENERAL INFORMATION ON WORKERS' COMPENSATION

Workers' Compensation coverage and benefits are provided under The Workers' Compensation Act (Act), O.S. Title 85. This state statute specifies who is covered, what injuries and diseases are covered and specifies the benefits to be paid to employees with injuries.

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)

CLAIM FORMS TO BE UTILIZED
WHEN AN INJURY OCCURS

Required forms

Employer's First Notice of Injury (Form 2)- This is the State of Oklahoma's required form to be completed by employer and submitted to CBR **and** Workers Compensation Court. CBR would be happy to provide you with a PDF tab and fill Form 2 that you could print from your computer to ensure that you have an acceptable copy for the Court. Please send your request to trenawilson@cbremail.com.

Requested Forms

These forms are completed by employer and/or employee and greatly expedite the claims process.

**Signature of injured worker is required on the last three forms

Medical Care Authorization Form - This form is used when the injured worker needs medical treatment away from the work site. Please complete the top portion and send the form with the injured worker to the medical provider. The medical provider should complete the lower portion of the form and mail it to CBR.

Injured Worker First Fill Prescription Form – This form is also 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 doctor.

Witness/Co-Worker Statement - This form should be completed by the person that witnessed the injury. This form is most useful on serious injuries as it documents who witnessed the incident or was involved in the incident.

The HIPPA Form- Authorization for Disclosure 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.

Report of Occupational Injury or Illness ** - To be completed by the employee **and** the supervisor/manager on the day the injury occurs. If the injury results in the need for immediate medical attention, please have the employee complete this form when physically capable and then forward to CBR. This form can be used to document an incident regardless of whether medical treatment is required.

Sick /Annual Leave Election Form **- This form should be completed by the employee and the employer. This form 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.

FORM 2

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

EMPLOYER'S FIRST NOTICE OF INJURY

THIS SPACE FOR COURT USE ONLY

Please type or print. Enter all dates in MM/DD/YY format.

Full Name of Claimant (Injured Employee) - LAST, FIRST, MIDDLE

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: A voluntary Mediation Program to address certain workers' compensation disputes is available through the Workers' Compensation Court. For information, call (405)522-8760 or (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

Place of Accident or Occurrence
City: County: State:

Injury Resulted From: Single Incident Cumulative Trauma | Does employer 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 UNKNOWN

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 (O.S.A.G. FDG WORKERS' COMPENSATION PLAN) Self-Insured Number:
Name CONSOLIDATED BENEFITS RESOURCES, L.L.C. Phone: (918)594-5170 Fax: (888) 594-5171
Address P.O. Box 581630 Tulsa, OK 74116 Policy Period - from _____ to _____

Employer's Name and Complete Address | Federal ID#: | Phone: | Fax:
Name:
Address: City: State: Zip:

Type of Business Public Education | SIC Number:

Type of Ownership: Private___ State Gov't__X__ County Gov't___ Local Gov't____

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 employee is receiving or any change in employee employment status, occurring during the period of receipt of such benefits.

I hereby declare under penalty of perjury that I have examined this notice, and all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

SIGNED THIS _____ DAY OF _____
PREPARED BY
TITLE _____

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

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.

07/08

OSAG

MEDICAL CARE AUTHORIZATION FORM

Approved First Responder Facility	After Hours

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 _____

☐	O.K. to return to regular duty on _____
☐	Return to see me on _____
☐	O.K. to work light duty beginning _____
☐	with the following limitations _____
☐	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 BILLTO:

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.

OSAG

*Injured Worker First Fill Prescription Form**

To be filled out by employer and given to injured worker

CONSOLIDATED
BENEFITS RESOURCES, L.L.C.

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.healthesystems.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

Healthesystems™

Temporary Member ID
(Pharmacist Use Only)

OSAG
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)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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.
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)

RETAIN COPY FOR YOUR FILE

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

Authorization for Disclosure of Protected Health Information

I,_____, authorize the disclosure of my protected health information [1] 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.

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1 Protected health information ("PH") 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 metal 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.

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.

Date of Injury:		Date Reported:		OSAG Member 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)			Comments, if any		
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)			Comments, if any		
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)			Comments, if any		
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:				

Employee's Statement **OSAG PAGE 2**

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:

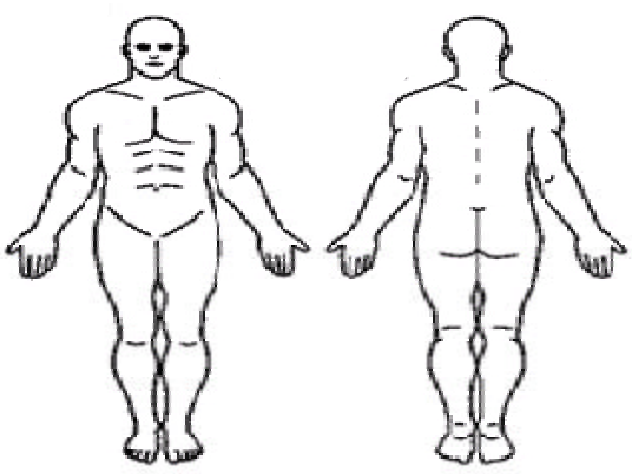
Have you discussed this pain with anyone at work? If yes, with whom and when? Yes No

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
N = Numbness	**S** = Stabbing
P = Pins & Needles	**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:

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:

Explanation of the "Workers' Compensation-Sick/Annual Accrued Leave Election Form

Title 85, known as the Workers' Compensation Act allows any injured public school employee to receive up to 70% of their wage, not to exceed $683 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 School 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 District can devise its own method, or possibly use one of the following methods that some Districts 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 District 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 District whereby the employee agrees to sign over any TTD checks back to the District. This method would still use the same 1/3 day of sick/personal leave for each day of TTD.

OSAG

Workers' Compensation-Sick/Annual Accrued Leave Election Form

The School District shall provide the benefits established under the Oklahoma Workers' Compensation Act to all School District 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 School District. 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 3 days of wages from my sick/personal accrued leave time.

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

(Note: if you are electing to be paid a supplement to your weekly workers' compensation benefits; and also to be paid for the 3-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

School District: _____ Department_____ Job Title_____

_____ _____
Signature of employee Date

Witness:_____
School District Representative