OCCUPATIONAL ACCIDENT RISK
MOVING FORWARD

CLAIMS REPORTING PACKET

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MOVING FORWARD

CONTACT US AT CLAIMS@OCCACCRISK.COM OR 877.467.7866 TO REPORT YOUR INJURY

If the injury is NOT a medical emergency:

1.) Upon notification of an occurrence, an Accident Loss Notice should be completed. Do not delay in reporting the claim, even if you don't have all the information. You will be notified of any additional information needed. Submit forms via email at claims@occaccrisk.com or call 877-467-7866

2.) The injured employee should complete the Employee Statement.

3.) The HIPAA release should be signed.

FOR **24/7 EMERGENCY** INCIDENT REPORTING, CALL **210.316.3781**

ALL MEDICAL BILLS SHOULD BE SUBMITTED TO:

OccAcc Risk, Inc.
P.O. Box 2414
Boerne, Texas 78006

INCIDENT REPORT

Date:____/____/____

Facility: _____

Location: _____ Contact: _____

Facility Phone #: _____ Fax #: _____

EMPLOYEE INFORMATION

Employee's Name: _____

Address: _____

Phone #: _____ Date of Hire:____/____/____

Occupation: _____ Weekly Pay Rate:$

SSN: _____ Date of Birth:____/____/____

ACCIDENT INFORMATION

Date of Loss:____/____/____ Time of Accident:____:____ Date Lost Time Began:____/____/____

Date Returned to Work:____/____/____ Date Reported to Employer:____/____/____

Supervisor's Name:

Address of Accident:

Witness: _____ Have you ever been treated for a similar injury? Y◯ N◯

Physician's Name: _____

Physician's Address: _____

Description of Accident: _____

_____

Nature of Injury (Body Part): _____

I certify that the above information is true and correct to the best of my knowledge. I understand that if I am declining medical treatment at this time that my Employer will not be responsible for any expense related to the Incident or any resulting injury. I further understand that I will not be eligible for benefits under the plan unless I receive medical care from an approved provider within 14 days from the date of incident.

Employee's Signature: _____

EMPLOYEE STATEMENT

Department/Division: _____

Employee's Name: _____

Address: _____

Phone #: _____

SSN: _____ Date of Birth: ____/____/____

Date of Injury: ____/____/____ Time of Injury: ____:____

ACCIDENT INFORMATION

Where did the injury occur? _____

Describe Injury: _____

_____

_____

Area of Body Injured: _____

Witnesses? Y ◯ N ◯ Name(s):

Employee Job Title: _____

Supervisor's Name: _____

Job being performed at the time of injury:

Date Reported to Supervisor: ____/____/____

I certify this is a true and accurate report of the circumstances which occurred on the date of my injury stated above:

Signature of Injured Employee: _____

Date: ____/____/____

Witness(es): _____

SUPERVISOR STATEMENT

Employee's Name: _____

Where did the injury occur? _____

Date of Injury: ____/____/____ Time of Injury: ____:____

List witnesses and phone numbers, including anyone that may have knowledge of the incident.

Name: _____ Phone #:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Did the employee lose work time due to alleged injury? Y ◯ N ◯

Did the employee go to the doctor? Y ◯ N ◯

Did the employee go to the doctor on their own? Y ◯ N ◯

Doctor's Name: _____

Hospital Name: _____

Phone #: _____

Has the employee returned to work? Y ◯ N ◯ (as of date of this report)

How long is the employee expected to be off work?

What happened? (Describe fully what took place.)

_____

_____

_____

Date Reported to Supervisor: ____/____/____ Time Reported to Supervisor: ____:____

Investigated by: _____

Title: _____

Phone #: _____ Date: ____/____/____

Supervisor's Signature: _____

Date: ____/____/____

WITNESS STATEMENT

Injured Employee's Name: _____

Date of Incident:____/____/____ Time of Incident:____:____

Witness' Name: _____

Address: _____

Phone #: _____

Where did the injury occur? _____

Are you related to the injured employee? Y ◯ N ◯ If "yes", how? _____

Same employer as injured employee? Y ◯ N ◯ If "no", employed by: _____

Did you actually see this injury happen? Y ◯ N ◯

If "no", how did you know about it? _____

Please explain in detail what you know about this incident:

Did this employee ever talk with you about getting hurt on the job? Y ◯ N ◯

If "yes", when did this conversation take place? Date:____/____/____ Time: ____:____

What did the employee say? _____

Do you know of any other injury, accident or illness this employee has had? Y ◯ N ◯

If "yes", explain: _____

Give the names of any other persons who might know about this accident/injury: _____

Additional Comments: _____

Witness' Signature: _____ **Date:**____/____/____

PLAN DE LESIONES EN EL TRABAJO EN TEXAS
REPORTE DEL INCIDENTE DEL EMPLEADO

INSTRUCCIONES: *Llene esta forma completamente, firme la forma donde indicado y regrese la original a su supervisor inmediato inmediatamente después de reportar su incidente relacionado con el trabajo.*

INFORMACIÓN DEL EMPLEADO

Nombre del Empleado: _____

Domicilio: _____

Teléfono: _____ Fecha Contratado:____/____/____

Ocupación: _____ Estado Civil: _____

SS: _____ Fecha de Nacimiento:____/____/____

Departamento/Localización: _____

INFORMACIÓN DEL INCIDENTE/EXPOSICIÓN

Fecha del Incidente:____/____/____ Hora del Incidente: ____:____

Fecha Reportada del Incidente:____/____/____ Hora Reportada del Incidente: ____:____

Reportado a: _____

Nombre del Supervisor: _____

Teléfono del Supervisor: _____

Lugar del Incidente: _____

Teléfono del Trabajo: _____

Nombre y teléfono de cada testigo.

Nombre: _____ Teléfono: _____

Nombre: _____ Teléfono: _____

Nombre: _____ Teléfono: _____

¿Qué hacía usted antes que sucedió el incidente? Describa la actividad, así como las herramientas, equipo, o materiales que usted utilizaba. Sea específico. _____

Describa lo que sucedió. Describa cómo la lesión actualmente ocurrió. _____

INFORMACIÓN DE LA LESIÓN

¿Ha sido tratado usted para una lesión similar antes? Sí ◯ No ◯

De ser así, por favor describa cualquier tratamiento previo que usted recibió y el nombre(s) y número(s) de teléfono del Proveedor(es) de Asistencia Médica que le proporcionó tratamiento previo:

La Naturaleza de la Lesión: _____

Parte del Cuerpo Lesionado: _____

Certifico que la información de arriba es verdadera y correcta mi entero conocimiento. Entiendo que si declino tratamiento médico en este momento, que mi Empleador no será responsable de ningún gasto relacionado al Incidente ni ninguna lesión resultante, a menos que el Plan me apruebe antes estos gastos. Entiendo aún más que yo no seré elegible para beneficios bajo el Plan a menos que reciba cuidado médico de un Proveedor Aprobado dentro de los primeros 14 días de la fecha del Incidente.

Firma Del Empleado: _____ **Fecha**: ____/____/____

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Plan Participant Name: _____ Date of Injury:____/____/____

Authorization: I hereby authorize any physician, hospital, pharmacy, health care provider, other health care facility, insurance company, prior employer or (specific any additional persons) _____

_____

to use with and disclose any of my medical records or other protected health information to, the following representative of (the "Plan"): (1) any claims adjuster, claims manager or authorized staff member of Occupational Accident Risk, Inc. and (2) The employer's representative and appeals committee members and their authorized staff members.

I further authorize such healthcare providers, persons and Plan representatives to use with, and disclose such protected health information to (1) Occupational Accident Risk, Inc.. authorized representative, authorized employees of the employers Human Resources, Risk Management, Safety Legal, Accounting/Payroll Employee Benefits and Information Technology (IT) Departments] (2) Supervisors **AND OR OTHER FIELD REPRESENTATIVES** (3) The Plan's Privacy Officer, (4) any medical case management group, repricing company, insurance agent, insurance carrier, consultant, attorney, business associate or other persons authorized by the employer or Occupational Accident Risk, Inc.. to perform business or legal services in connection with my work-related incident referenced above and (5) (specify any additional persons: _____

_____

Purpose of Authorizations: I understand that this Authorization is given for the following purposes only: (1) the treatment of any occupational illness/injuries allegedly arising from my work-related incident referenced above, such as discussion of my diagnosis, treatment, prognosis and overall health condition; (2) the payment of any claim for Plan benefits, such as pre-authorization of medical treatment, case management and making benefit determinations; (3) the health care operations of the Plan, such as claims audits, coordination of benefits/ subrogation and the renewal or replacement of Plan related insurance; (4) the assessment of my ability to qualify for a leave of absence or return to full or modified job duties; (5) the use and disclosure of post-accident drug & alcohol test results; (6) assisting me (or my Authorized Representative below) with benefit claims or other Plan-related issues; (7) liability and safety evaluations and activities, and (8))please specify and additional reason(s):

_____

Acknowledgement: By signing below, I understand and acknowledge that (1) this authorization shall expire on the date upon which I am no longer eligible for plan benefits; (2) I have the right to revoke this Authorization by contacting the following person in writing Occupational Accident Risk, Inc. **P O Box 2414 Boerne, 78006** - however, this revocation will not apply to any use or disclosure made prior to the plan's receipt of my revocation; (3) the Plan may not condition treatment, payment, enrollment or eligibility for benefits solely on whether I sign this Authorization; (4) there is a potential that my protected health information used and disclosed in accordance with this Authorization may be re-disclosed by certain persons receiving this information and may then no longer be protected by federal law and (5) I am entitled to a copy of this Authorization and that a photocopy of this

Plan Participant's Signature: _____ **Date:**____/____/____

Witness' Signature: _____ **Date:**____/____/____

OFFER OF MEDICAL TREATMENT DECLINED

I, _____ , declined medical treatment on this date for an accident and any resulting injury sustained on the date of____/____/____.

I am aware that _____ will not be responsible for any medical expenses unless specifically pre-approved.

Employee's Signature: _____

Date:___/___/___

Witness' Signature: _____

Date:___/___/___