

How to Process Your Workers' Compensation Insurance Claim

The following are steps needed to insure your claim is processed in a timely manner:

1. Immediately report your injury to your supervisor and pick up an Injury Packet from the Security Department/Human Resources.
2. Seek medical attention.

IMPORTANT: Your employer/Tribal First reserves the right to direct your care to a provider of their choice. Please check with your employer, before seeking medical attention, to verify whether or not a provider has already been selected.

3. Have the attending physician complete the Physicians Initial Report included in this packet. You may leave this form with your physician, and he/she will forward it to the insurance company listed on the form. Your attending physician should also complete the Return to Work Authorization form. This form needs to be returned to Trina Dunegan to be forwarded to Tribal First with your Accident Report.
4. Complete the upper portion of the Accident Report included in this packet. This should be completed within two days of the injury. **Return the completed form to the Trina Dunegan via email at tdunegan@cmse.net or fax to (580) 924-5764.** Trina Dunegan will complete the bottom portion of the accident report and forward to Tribal First.
5. As soon as Tribal First receives your completed accident report, your claim will be processed and a claim number assigned. **If Tribal First does not receive a completed form, time loss or medical benefits cannot be provided.**

If you have any questions regarding the completion of this packet, please contact Trina Dunegan (888) 924-7774 ext. 2151. You may contact the claims examiner for additional information at Tribal First at 1-877-777-8039.

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS	Tribal First / NovaPro Risk Solutions 4313 6th Avenue SE, Suite A Lacey, WA 98503 Fax: (360) 413-9291	<input type="checkbox"/> Fatality
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E M P L O Y E R	1. FIRM NAME	1A. POLICY NUMBER	DO NOT USE THIS COLUMN
	2. MAILING ADDRESS (Number and Street, City, Zip)	2A. PHONE NUMBER	Case No.
	3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP)	3A. LOCATION CODE	Ownership
	4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.		Occupation

E M P L O Y E E	5. EMPLOYEE NAME	6. SOCIAL SECURITY NUMBER	7. DATE OF BIRTH (mm dd yy)	Age		
	8. HOME ADDRESS (Number and Street, City, ZIP)			8A. PHONE NUMBER	Daily hours	
	9. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	10. OCCUPATION (Regular job title - NO initials, abbreviations or numbers)		11. DATE OF HIRE (mm dd yy)	Days per week	
	12. EMPLOYEE USUALLY WORKS hours per day _____ days per week _____ total weekly hours _____		12A. EMPLOYMENT STATUS (check applicable status at time of injury) regular full time _____ part-time _____ temporary _____ seasonal _____		12B. DEPARTMENT CODE	Weekly hours
	13. GROSS WAGES SALARY \$ _____ per _____		14. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging overtime, bonuses, etc.)? <input type="checkbox"/> YES, \$ _____ per _____ <input type="checkbox"/> NO			
	14. Have you ever injured or received treatment to the same body part? <input type="checkbox"/> YES <input type="checkbox"/> NO					
	15. Do you have more than one paying job? <input type="checkbox"/> YES <input type="checkbox"/> NO		15A. Married? <input type="checkbox"/> YES <input type="checkbox"/> NO		15B. Dependents? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	MEDICAL RELEASE AUTHORIZATION: I hereby authorize my physician, hospital, agency, or organization to disclose to my employer or their representatives, any medical records or other information regarding treatment which has previously been furnished to me. NOTICE: Indian reservations are sovereign nations and are not subject to the state or federal workers' compensation laws. By completion of this form you are submitting to the sole jurisdiction of the tribe. NOTICE: Making or causing to be made any knowingly false or fraudulent material statement written or oral, or purposefully withholding material information in order to receive compensation is unlawful and will result in a denial of benefits, penalties, and/or prosecution.					

I N J U R Y O R I L L N E S S	17. DATE OF INJURY OR ONSET OF ILLNESS (mm dd yy)	18. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.	19. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.	20. IF EMPLOYEE DIED, DATE OF DEATH (mm dd yy)	Weekly wage	
	21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		22. DATE LAST WORKED (mm dd yy)	23. DATE RETURNED TO WORK (mm dd yy)	24. IF STILL OFF WORK, CHECK THIS BOX <input type="checkbox"/>	County
	25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> YES <input type="checkbox"/> NO	26. SALARY BEING CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO	27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm dd yy)		28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm dd yy)	Nature of injury
	29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning.					Part of body
	30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)			30A. COUNTY	30B. ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO	Source
	31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g. shipping department, machine shop.				32. OTHER WORKERS INJURED/ILL IN THIS EVENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	Event
	33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.					Sec. Source
	34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck					Extent of injury
	35. HOW INJURY/ILLNESS OCCURRED, DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.					
	36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)				36A. PHONE NUMBER	
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)				37A. PHONE NUMBER		

Employer comments/concerns			
Completed by (type or print)	Signature	Title	Date

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY

1 I.D. NUMBER

PHYSICIANS INITIAL REPORT

2 CLAIM NUMBER

MAIL TO EMPLOYER'S SERVICE REP.

3 NAME OF EMPLOYER

3a NAME OF EMPLOYER'S SERVICE REPRESENTATIVE
NOVAPRO/TRIBAL FIRST
4313 6TH AVENUE SE, SUITE A
LACEY, WA 98503

EMPLOYER'S TELEPHONE NO. EMPLOYER'S SERVICE REP PHONE
1-877-777-8039

Physician — START HERE

17 Date patient first seen by you for this injury/condition

18 ICDM-9 CODE Diagnosis - Specify Right / Left

18 Are there objective findings to support this diagnosis
 No Yes, Specify

19a Referred for Diagnostic Studies (X-Ray)
 No Yes, Specify

19b Referred for Diagnostic Studies (Lab)
 No Yes, Specify

c Other Studies & Findings

d Remarks

50 IRS Account #

PATIENT INFORMATION

4 NAME OF INJURED WORKER: FIRST MIDDLE LAST 5 WORKER'S TELEPHONE NO.

6 MAILING ADDRESS 7 SOCIAL SECURITY NUMBER

8 CITY STATE ZIP CODE 9 DATE OF BIRTH

10 DATE OF INJURY 11 TIME A.M. P.M. 12 SEX 13 MARITAL STATUS / DEPENDENTS

14 Worker Statement of Incident

15 Signature 16 Date

20 Answer to the best of your knowledge
a HAS WORKER EVER BEEN TREATED FOR PRESENT OR SIMILAR CONDITION? YES NO
b IS THERE ANY PRE-EXISTING IMPAIRMENT OF THE AREA INJURED? YES NO
c WILL ANY PRE-EXISTING CONDITION COMPLICATE TREATMENT OR RETARD RECOVERY? YES NO
d IS THE CONDITION DIAGNOSED THE RESULT OF THE INCIDENT DESCRIBED ON A MORE PROBABLE THAN NOT BASIS? YES NO

21 Treatment Provided / Ordered
a) Type YES NO
Drugs Rx'd
Chiropractic / ospath adjustment
Casted
Sutured
Surgery
Hospitalized
Where?
b) If further treatment needed, date of next visit

22 Employment information
a) Can this Worker return to regular work? Yes No When
b) Can this Worker return to light duty? Yes No When
c) What restrictions are placed on RTW? Lifting Bending Standing Sitting Other
d) Estimate Time Loss in Days:

23 Referred to: Address
Dr. City State Zip Phone

Licensed Physician must sign before report is accepted
24 Signature 25 Phone 26 Date

27 Physician Name (Print or Type)
28 Address Zip

DO NOT SEND THIS FORM TO

LABOR & INDUSTRIES



Date: _____
Injured Worker Name: _____
Claim Number: _____

**RETURN TO WORK AUTHORIZATION
DISABILITY CERTIFICATE**

_____ The injured worker is medically and physically able to perform work without restrictions effective _____.

_____ The injured worker is released for light duty/modified work with the following restrictions: _____

Anticipated duration of disability is _____
Please provide the objective medical findings to support disability. ***This is required:*** _____

_____ The injured worker is not released to any type of work based on the following: Please provide the objective medical findings to support disability. ***This is required:*** _____

Anticipated duration of disability is _____

The injured worker requires further treatment ___ Yes ___ No
Diagnosis of all work related conditions are: _____

Next appointment date _____

Comments: _____

Physician Signature

Print Name

Date:

Phone Number