CONSOLIDATED
BENEFITS RESOURCES
MEMBER NATIONAL COUNCIL OF SELF-INSURERS

OSAG

Welcome to CBR! Please distribute this packet to the Workers' Compensation Coordinator and have them replace any old forms you may have on file.

You may ask, "Who is CBR?" Consolidated Benefits Resources (or "CBR"), is an Oklahoma based third party administration ("TPA") firm maintaining claims offices in Oklahoma City and Tulsa. CBR has been in the TPA business in Oklahoma for over forty (40) years and we have first-hand-knowledge that they provide a great service! Please see the following short overview of what to expect:

1. **Team Approach to Claim Handling**. CBR employs 31 licensed claims adjusters. Eight (8) 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 help with your needs.

2. **Medical Bill Review Reduction**. CBR and Equian, our bill review company, reduced medical provider bills by 62% in 2015. 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 in the plan too.

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.

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

CLAIMS ARE MOST EFFECTIVELY RESOLVED WHEN REPORTED WITHIN 24 HOURS OF THE EMPLOYEE'S REPORT OF INJURY.

STEP 1

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

State law requires medical treatment to be offered within 5 days of the notice of injury to retain employer choice of treating physician. If treatment not offered within 5 days of notice of injury, the employee can choose the treating physician, so it is important to obtain treatment as soon as possible. If the employee refuses medical treatment, have them sign a statement that they refused treatment and send it to CBR.

NOTE: If the employee misses more than 3 days of work, please send a copy of the CC-Form 2 to the Oklahoma Workers' Compensation Commission, within 10 days of the notice of injury, per Commission Rule 810:10-1-4. Please make sure the Form is legible and all fields are fully completed or the Form may be returned.

STEP 2

After sending a CC-Form 2 to CBR, forward any medical bills to CBR and ask the medical provider to send their bills directly to CBR as well. Please do not send duplicate copies of your "CC-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 Title 85A. (the "Act"). This statute specifies who is covered, what injuries and diseases are covered and specifies the benefits to be paid to injured employees.

CONSOLIDATED BENEFITS RESOURCES

CLAIM FORMS TO BE UTILIZED WHEN AN INJURY OCCURS

REQUIRED FORM

Employer's First Notice of Injury (CC-Form 2). This is the State of Oklahoma's required form to be completed by the employer when an employee is injured on the job. CBR would be happy to provide you with a PDF tab and fill CC-Form 2 that you could print from your computer to ensure that you have an acceptable copy for the Commission. Please send your request to trenajones@cbremail.com. **The employee's name should match their social security card (no nicknames).** As a reminder, please send a CC-Form 2 to CBR as soon as possible after all on the job injuries. Only send the Commission a copy if the employee misses more than 3 days of work.

REQUESTED FORMS

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

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.

REQUESTED FORMS - SIGNED BY INJURED WORKER

Consent 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.

Medicare SSDI Questionaire This from provides information in order for CBR to correctly report required claims to Medicare. All injured employees should complete and sign.

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.

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MEDICAL CARE AUTHORIZATION FORM

Approved First Responder Facility	After Hours

TO BE COMPLETED BY 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 _____

☐ Post accident drug screen performed? Yes/ No _____

☐ O.K. to return to regular duty on _____

☐ Return to see me on _____

☐ O.K. to work light duty beginning _____

with the following limitations _____

(Note: It is the philosophy of this company to provide modified duty work when possible.)

☐ Unable to return to work until _____

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, DME's or referrals need to be preauthorized by Consolidated Benefits Resources.

Notice Prescriptions: If prescriptions are appropriate, please give the patient a written prescription. Prepackaged prescriptions are not authorized.

PLEASE FORWARD THE COMPLETED ORIGINAL FORM AND YOUR BILL

CONSOLIDATED BENEFITS RESOURCES

Post Office Box 13770
Oklahoma City, Oklahoma 73113
405.848.3387 *telephone*
800. 822.5733 *toll free telephone*
405.840.4298 *facsimile*
800. 898.6465 *toll free facsimile*

Healthesystems Injured Worker First Fill Prescription Form

Instructions for: Employer*

Please complete this form before providing to Injured Worker.

*Last Name, First Name:	*Social Security Number:
*Date of Injury:	*Date of Birth:
*Employer Name:	

*Required Information

Instructions for: Injured Workers*

To fill your initial (first) prescriptions for a workers' compensation injury, follow these easy steps:

1. Present this form within 15 days of the date you were injured.
2. Locate a participating pharmacy closest to you. For assistance use the following tools:
   - Call: 1.800.758.5779
   - Visit: www.healthesystems.com and click on "Pharmacy Search" located under the "Pharmacy Tools button"
   - A sample listing of pharmacies are provided at the bottom of *this form*

**For new injuries only*

Instructions for: Pharmacists

Your pharmacy has contracted to participate in the Healthesystems Pharmacy Network. To dispense the patient's first-fill for their workers' compensation prescription:

- Indicate that this is a new workers' comp injury; do not process under an existing injury
- Call the Healthesystems Customer Service Center: 1.800.758.5779
- Process using the Member ID # provided by Healthesystems

Prescription Processing Information:
Transmit prescription using the following

Healthesystems Customer Service Center phone number: **1.800.758.5779** (press 1 for retail pharmacy option)		
BIN: **012874**	Carrier/Customer ID: ***Consolidated Benefits Resources/6000CBRS***	* Member ID: *(provided by Healthesystems CSC representative)*

*Required Information

Healthesystems Pharmacy Network

Bi-Lo Pharmacy	Homeland Pharmacy	Medicine Shoppe	Rexall Drug	Tyler Drug
Buy For Less Pharmacy	Hutton Pharmacy, Inc	Osborn Drugs	Rite Aid	Walgreens
Costco Pharmacy	Kmart	Pharmacy Solutions, LLC	Sam's Club	Wal-Mart
CVS Pharmacy	Lassiter Drug	Pharmcare OK Inc	Spoon Drugs Inc	Winn Dixie Pharmacy
Drug Warehouse	Mays	Pyramid Pharmacy	T M Pharmacy Inc	Western Oaks Pharmacy
Fountain Park Pharmacy	Med-X Drug	Ralphs Pharmacy	Target	Westview Pharmacy
Harrison Discount Drug	Medicap Pharmacy	Reasors Pharmacy	The Apothecary	

Call 1.800.758.5779 or visit www.healthesystems.com to see a full list of network pharmacies.

The injured Worker, in many states, has the free, full and absolute choice in the selection of a pharmacy or pharmacist. The above information is provided if the injured worker needs assistance in locating a pharmacy.

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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

RETAIN COPY FOR YOUR FILE

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

Consent for Release of Protected Health Information

I, _____(Circle) Patient, Parent, Guardian, legal custodian of:

_____ SSN: ____ ____ ____ DOB:_____ _____ _____
(NAME OF PATIENT)

authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name of individual/company to receive PHI:

Workers' Compensation Claims
Consolidated Benefits Resources
P.O. Box
, Oklahoma

Name of individual/company to disclose PHI:

_____

_____

Information authorized for use or disclosure, or to be obtained:

☐ All medical information concerning this patient.

☐ Medical information of this patient compiled between the dates of _____and _____.

☐ Only:_____

The information will be obtained, used and/or disclosed for the following purpose(s) only:

☐ Insurance ☐ Continued treatment ☐ Legal ☐ At the request of the patient or patient's representative

☐ Workers' Compensation Benefits ☐ Other (specify) _____

Date Authorization expires: _____ (if no date is selected, this Authorization will expire in one (1) year from the date signed below).

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation to Claims Manager of Consolidated Benefits Resources.
- I release the entities listed above, their agents and employee from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will be compensated by the recipient for the disclosure, except for the cost of copying and mailing as permitted by law.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse confidentiality requirements.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

The information I authorize for release may include records which may indicate the presence of a communicable or noncommunicable disease, or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). I further understand that my medical information may indicate that I have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____
Signature of Patient or Representative **Date** **Employer**

_____ _____
Representative's Relation to Patient **Employer Address**

_____ _____
Signature of Witness **Date** **Date Authorization expires**

Notice of Rights: Information in your medical records that you have or may have a communicable or noncommunicable disease or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have risk exposures, disclosure pursuant to order of a court or the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, or by an order of a court or the Department of Health.

A COPY IS AUTHORIZED AS AN ORIGINAL

Mandatory Medicare Reporting Requirement

******* Please complete this form with each report of injury*******

The Centers for Medicare & Medicaid Services require mandatory reporting of workers' compensation claims. Please complete the following to see if this is an eligible claim to report.

To be completed by the employee (Please print)

Date: _____

Injured Worker Name: _____
(Name as it appears on your social security card)

Social Security Number: XXX-XX-_ _ _ _ Date of Birth:_____

Dear Injured Worker, please provide an answer to the following questions:

YES	NO	
☐	☐	**Are you currently on SSDI? (Social Security Disability)**
☐	☐	**Have you ever applied for SSDI?**
☐	☐	**Do you anticipate filing for SSDI within the next 30 months?**
☐	☐	**Are you a Medicare beneficiary?**
☐	☐	**Have you or are you currently participating in a Medicare Advantage Plan?** (This is a Medicare supplement product purchased from a private carrier such as Humana, Blue Cross Blue Shield etc.)
☐	☐	**Do you anticipate filing for Medicare benefits in the next 30 month?**

_____

Signature of Injured Worker Date

PLEASE FORWARD THE COMPLETED FORM TO:

CONSOLIDATED BENEFITS RESOURCES
Post Office Box 13770
Oklahoma City, Oklahoma 73113
405.848.3387 telephone
800. 822.5733 toll free telephone
405.840.4298 facsimile
800. 898.6465 toll free facsimile

SSDIANSWER

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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.

Supervisor Section

Date of Injury:		Date Reported:		Employer Name:	
Name of Employee:			S.S. No:	XXX-XX- (last four digits)	
Home Address, City, Zip Code:					
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)

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)

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)

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	**Employer:**		**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?

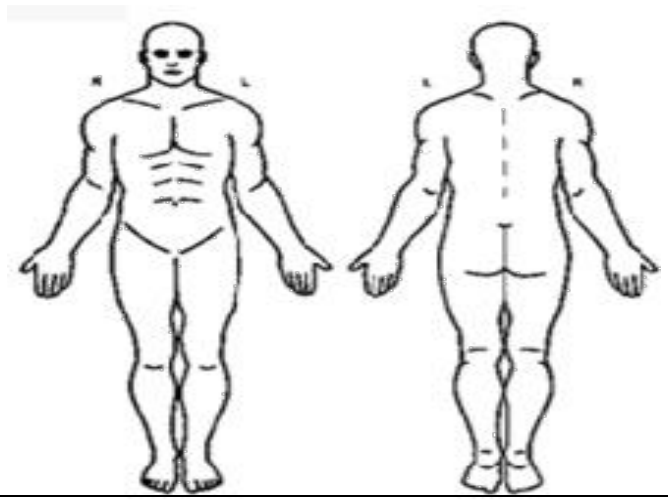
List body parts injured:

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 die 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	**P** = Pins & Needles
N = Numbness	**S** = Stabbing	**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 sever pain, unbearable

Was medical treatment away from the job site offered?

Yes No

If treatment was offered, but declined, please sign:

Have you ever received medical treatment for the injured body part(s) listed above? If so, please note the date and physician/hospital where treatment was rendered.	Yes	No	
Are you currently receiving Social Security **Disability** Payments (*not Social Security retirement payments*)?	Yes	No	
Are you currently receiving Medicare assistance?	Yes	No	
Do you currently have a Child Support Lien	Yes	No	

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:		**Date:**	

Workers' Compensation-Sick/Annual Accrued Leave Election Form

The Educational Institution shall provide the benefits established under the Administrative Workers' Compensation Act to all educational institution employees who are injured in a on-the-job accidents. All regular employees who are injured in a 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 educational institution. As a result of the injury, I acknowledge that I am entitled to receive temporary disability compensation according to the Administrative Workers' Compensation Act 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 ____days from my sick/personal accrued leave time.

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

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

Institution: _____ Department _____ Job Title _____

_____
Signature of Employee Date

Witness:_____
Institution Representative