HENRY COUNTY FLOW CHART OF REPORTING A WORKMAN COMP CLAIM

EMPLOYEE IS SERIOUSLY INJURED...
If injury results in death or overnight hospital stay, immediately contact Supervisor, and dispatch to notify a Commissioner and/or Human Resources.

EMPLOYEE IS INJURED ...
Notify immediate Supervisor and act accordingly to injury / incident. First options include:
* HealthLink, New Castle, IN 765-521-1500
* First Care, New Castle, IN 765-518-8100
* Immediate Care, New Castle, IN 765-599-3100
* If injuries are life threatening go to nearest ER

COMPLETE FORMS AND SUBMIT TO HUMAN RESOURCES
WITHIN 24 HOURS OF INJURY / INCIDENT

1. **FIRST REPORT OF INJURY (Completed by Employer)**
2. SUPERVISOR'S INCIDENT REPORT (Completed by Employer)
3. MEDICAL AUTHORIZATION FORM (Completed by Employee)

abankson@henryco.net
Fax: (765) 521-7037

IS TREATMENT REQUIRED?

YES

DIRECT EMPLOYEE TO DESIGNATED OCC HEALTH CLINIC OR ER

CONTACT IPEP FOR REFERRALS OF CARE NURSE

NO

CLAIM IS SET UP AS A RECORD ONLY WITH IPEP

CONTACT IPEP ASAP IF TREATMENT BECOMES NECESSARY

IPEP
30 Years Strong 1989-2019

State Form 34401 (R10 / 1-02)

Please return completed form electronically by an approved EDI process.

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION

Social Security number	Date of birth	Sex ☐ Male ☐ Female ☐ Unknown	Occupation / Job title	NCCI class code
Name (*last, first, middle*)		Marital status ☐ Unmarried ☐ Married ☐ Separated ☐ Unknown	Date hired / State of hire	Employee status
Address (*number and street, city, state, ZIP code*)			Hrs / Day / Days / Wk / Avg Wg / Wk	☐ Paid Day of Injury ☐ Salary Continued
Telephone number (include area		Number of dependents	Wage $ Per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year ☐ Other	

EMPLOYER INFORMATION

Name of employer	Employer ID#	SIC code	Insured report number
Address of employer (*number and street, city, state, ZIP code*)	Location number	Employer's location address (*if different*)	
	Telephone number		
	Carrier / Administrator claim number	OSHA log number	Report purpose code
Actual location of accident / exposure (*if not on employer's premises*)			

CARRIER / CLAIMS ADMINISTRATOR INFORMATION

Name of claims administrator	Carrier federal ID number	Check if appropriate
Indiana Public Employers Plan (IPEP)		☒ Self Insurance
Address of claims administrator (*number and street, city, state, ZIP code*)	☐ Insurance Carrier	Policy / Self-insured number
PO Box 690, Kokomo IN 46903	☒ Third Party Admin.	
Telephone number		Policy period
800-382-8837 765-868-3310 FAX		From To
Name of agent	Code number	

OCCURRENCE / TREATMENT INFORMATION

Date of Inj./ Exp.	Time of occurrence ☐ AM ☐ PM ☐ Cannot be determined	Date employer notified	Type of injury / exposure	Type code
Last work date	Time workday began	Date disability began	Part of body	Part code
RTW date	Date of death	Injury / Exposure occurred on employer's premises? ☐ Yes ☐ No	Name of contact	Telephone number
Department or location where accident / exposure occurred			All equipment, materials, or chemicals involved in accident	
Specific activity engaged in during accident / exposure			Work process employee engaged in during accident / exposure	
How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.				Cause of injury code
Name of physician / health care provider				
Hospital or offsite treatment (*name and address*)				INITIAL TREATMENT ☐ No Medical Treatment ☐ Minor: By Employer ☐ Minor: Clinic / Hospital ☐ Emergency Care ☐ Hospitalized > 24 Hours ☐ Future Major Medical / Lost Time Anticipated
Name of witness	Telephone number	Date administrator notified		
Date prepared	Name of preparer	Title	Telephone number	

An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13).

INSTRUCTIONS

General Instructions:

1. Please enter information into all of the areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.

2. Enter all dates in MM/DD/YY format.

3. Please return completed form electronically by an approved EDI process.

4. For answers to questions, please call (317) 232-3808.

Definitions:

AGENT NAME AND CODE NUMBER: Enter the name of your insurance agent and his / her code number if known. This information can be found on your insurance policy.

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED: List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and / or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (*e.g. Acetylene cutting torch, metal plate, etc.*).

AVG WG/WK: Claimant's average weekly wage, calculated by totaling the latest 52 weeks of wages (*including overtime, tips, etc.*) and dividing by 52.

CLAIMS ADMINISTRATOR: Enter the name of the carrier, third-party administrator, state fund, or self-insured responsible for administering the claim.

CONTACT NAME / TELEPHONE NUMBER: Enter the name of the individual at the employer's premises to be contacted for additional information (*i.e. Supervisor, HR Person, Nurse, etc.*)

DATE DISABILITY BEGAN: The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwised deigned by statute.

DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED: If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (*e.g. Maintenance, Client's Office, Cafeteria, etc.*).

EMPLOYEE STATUS: Indicate the employee's work status from the following choices: Full-time, Part-time, Apprentice Full-time, Apprentice Part-time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as: (*FT, PT, AFT, APT, VO, SW, PW, OS, DI, RE, NE, or UK*).

HOW INJURY / ILLNESS OCCURRED: Describe the sequence of events leading to the injury or exposure (*e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall*).

NCCI CLASS CODE: A four-digit code classifying the occupation of the claimant.

OCCUPATION / JOB TITLE: Enter the primary occupation of the claimant at the time of the accident or exposure.

PART OF BODY AFFECTED: Indicate the part of body affected by the injury / illness (*e.g. Right forearm, Low Back, etc.*)

REPORT PURPOSE CODE: 00 = Original First Report of Injury; 02 = Updated or Amended First Report.

RTW DATE (*Return to Work Date)*: Enter the date following the most recent disability period on which the employee returned to work.

SIC CODE: This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT / EXPOSURE: Describe the specific activity the employee was engaged in during the accident or exposure (*e.g. Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting*).

TYPE OF INJURY / ILLNESS: Briefly describe the nature of the injury or illness (*e.g. Contusion, Laceration, Fracture, etc.*)

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT / EXPOSURE: Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (*e.g. Building maintenance*).

INDIANA PUBLIC EMPLOYERS' PLAN, INC.

SUPERVISOR'S INCIDENT INVESTIGATION REPORT

(Please Complete All Sections)

1. Company or Location
2. Department
3. Date of Incident/Day of Week

4. Exact Location of Incident
5. Time of Occurrence (am/pm)
6. Date Reported

7. Name of Injured
8. Occupation
9. Body Part Affected (See Back)

10. Nature of Injury or illness (See Back)
11. Item Inflicting Injury/Illness
12. Type of Accident (See Back)

13. Person With Most Control of Item 11.

14. Description of the Incident

15. Direct Causes of Incident
16. Why Each Cause Exists

17. Actions Taken or Needed to Prevent Recurrence
18. Date Completed

19. Investigated By
20. Date
21. Reviewed By
22. Date

Please mail form to: IPEP
P.O. Box 690
Kokomo, IN 46903-0690

Toll free: 1-800-382-8837
Claims Fax: 1-765-868-3310
Local: 1-765-457-9161

Type of Accident

Bite by Animal
Bite by Human
Bite by Insect/Sting
Body Reaction
Burn
Caught In/Between/On
Contacted Harmful Substance
Contagious Disease Exposure
Electrical Contact
Fall From
Fall Level
Fell Through
Foreign Body
Gunshot
Motor Vehicle
Other
Overexertion
Pierced/Punctured By
Public Transportation
Repetitive Action/Motion
Slipped (Not Fall)
Smoke Inhalation
Stepped In/On
Stress
Struck Against
Struck By
Struggle/Resistive Subject

Nature of Injury

Abrasion
Amputation
Asphyxia
Avulsion
Bruise, Contusion
Burn Caused by Chem.
Burn Caused by Heat
Carpal Tunnel Syndrome
Concussion
Cut, Laceration
Crush
Death
Dermatitis
Dislocation
Electrical Shock
Fracture
Frostbite/Freezing
Hearing Loss
Heart Attack
Heat Stroke
Hernia
Infection
Inflammation/Swelling
Multiple Injuries
Other
No Injuries
Poisoning
Puncture
Radiation
Soreness/Pain
Sprain/Strain
Stress
Tendonitis

Part of Body

Abdomen
Arm - Lower
Arm - Upper
Back/Spinal, Back/Non-spinal
Buttocks
Chest
Ears, External
Ears, Internal
Elbow
Eyes
Face
Fingers
Foot
Groin
Hand
Head
Hips
Jaw
Knee
Leg - Lower
Leg - Upper
Mouth
Multiple Parts
Neck/Spinal, Neck/Non-spinal
Nervous System
Nose
Other
Respiratory System
Shoulder
Teeth
Thigh
Thumb
Toes
Trunk/Non-spinal
Wrist

Indiana Public Employers' Plan, Inc.
P.O. Box 690
Kokomo, IN 46903-0690

Toll free: 1-800-382-8837
Local: 1-765-457-9161
Claims fax: 1-765-868-3310

Adjuster: Claim No:

AUTHORIZATION FOR RELEASE OF MEDICAL, MILITARY, EDUCATION AND WAGE INFORMATION

To any physician, dentist, hospital, health care practitioner, military authority, education authority, employer or insurance carrier:

The requested information is needed to accurately evaluate, adjust and pay the patient's insurance claim.

I hereby authorize any health care professional (including health care physicians, medical practitioners or other health care providers, hospitals, medical attendants, nurses, x-ray technicians, or any other person), military authority, education authority, employer or insurance carrier, to furnish to the insurance company named above or its authorized vendors and representatives, wage loss and individually identifiable health information regarding my injuries, payment, treatment rendered, or health care received or provided. I understand that this authorization is voluntary.

I agree that a photocopy or fax of the original authorization shall have the same force and effect as the original.

I understand that my health care records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

I understand that I may revoke this authorization at any time by notifying the health care professional(s) in writing, but if I do it will not have any affect on any actions taken before receipt of the revocation.

I understand that once disclosed, the information and documentation released may be re-disclosed and may no longer be subject to the HIPAA Privacy Rule.

This disclosure is made at the request of the individual named below for the purposes of evaluation, adjusting and paying an insurance claim.

Unless otherwise required by law, this authorization shall expire upon the final resolution of the insurance claim.

By signing below, the patient acknowledges that he/she has read the fraud statement printed below.

PATIENT OR REP SIGNATURE

PATIENT ADDRESS

PATIENT NAME OR REP (PLEASE PRINT)

CITY, STATE, ZIP

REPRESENTATIVE'S RELATIONSHIP TO PATIENT

PATIENT PHONE NUMBER

DATE

SOC SEC NUMBER

DATE OF BIRTH

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION COMMITS A FELONY.

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