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Basic Accident Report

Date of Report:_____ Report Completed By:_____

Last Name of Injured Person:	First Name:	Job Title:
Date of Accident:	Time of Accident:	Location of Accident:
Supervisor's Name & Job Title:	Name of Witnesses:	
Full Description of Injuries:		
Description of accident/incident or employee's account, including sequence of events preceding the accident:		
Basic cause and contributory causes. Explain fully unsafe act, unsafe condition, personal factor, other:		
Recommended Corrective Measures:		Action By:
Names of Inspection Team Participants:		
Management Review By:	Date to be Completed By:	

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Informe Básico de Accidentes

Fecha Del Informe:_____Informe Completado Por:_____

Apellido De La Persona Lesionada:	Primer Nombre:	Puesto De Trabajo:
Fecha Del Accidente:	Hora Del Accidente:	Lugar Del Accidente:
Nombre Del Supervisor Y Cargo:	Nombre De Los Testigos:	
Descripción Completa De Las Lesiones:		
Descripción del accidente / incidente o versión del empleado, incluyendo la secuencia de eventos que preceden al accidente:		
Causas básicas y causas contributivas. Explique el tipo de situación ya sea si fue una situación insegura, condición insegura, factor personal, otros:		
Medidas Correctivas Recomendadas:		Acciones Tomadas Por:
Nombres De Los Participantes Del Equipo De Inspección:		
Revisión Por Parte De La Gerencia:	Fecha Límite De Entrega:	

One good reason to think twice about workers' compensation fraud

EMPLOYERS® actively investigates suspected workers' compensation fraud and reports such cases to law enforcement authorities.

fraud costs

Workers' compensation fraud costs $7.2 billion annually.[1]

Filing a fraudulent workers' compensation claim could lead to serious civil or criminal consequences, such as fines, incarceration and/or restitution.

If you suspect workers' compensation fraud, please contact EMPLOYERS' Fraud Investigations Department. Call the Fraud Hotline at 1-800-750-3939 or e-mail fraudfighters@employers.com.

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1 Source: http://www.propertycasualty360.com/2015/07/23/3-keys-to-a-successful-workers-compensation-fraud

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REV 09/2015

Una buena razón para pensarlo dos veces antes de cometer fraude en una demanda de indemnización laboral

EMPLOYERS® investiga de manera activa casos sospechosos de cometer fraude en una demanda de indemnización laboral y reporta dichos casos a las autoridades policiales.

costos del fraude

Fraude en demandas de indemnización laboral cuesta $7.2 mil millones al año.[1]

Presentar una demanda de indemnización laboral fraudulenta puede acarrear graves consecuencias civiles o penales, tales como multas, cárcel y/o indemnizaciones.

Si sospecha que existe fraude en una demanda de indemnización laboral, póngase en contacto con el Departamento de Investigación de Fraude de EMPLOYERS. Llame a la línea directa de fraude al 1-800-750-3939 o escriba al correo electrónico fraudfighters@employers.com.

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1 Fuente: http://www.propertycasualty360.com/2015/07/23/3-keys-to-a-successful-workers-compensation-fraud

CM_0077IF_US
REV 09/2015

OPTUM®

PO Box 152539
Tampa, FL 33684-2539

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MAKING IT EASY TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured person:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacy will fill the prescription at no cost to you.

If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Employer:

Immediately upon receiving notice of injury, fill in the information below and give this form to the employee.

Finding a network pharmacy

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

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WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Employers
CARRIER/TPA — EMPLOYER

INJURED PERSON NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER — DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	EMPLFF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

tmesys®

IMP14-2013-84

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Tampa, FL 33684-2539

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HACEMOS MÁS SENCILLO QUE SE LE ABASTEZCA LAS RECETAS DE SU PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Persona lesionada:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información que aparece a continuación y entregue este formulario al empleado.

Cómo encontrar una farmacia de la red

La mayoría de farmacias y todas las grandes cadenas de farmacias forman parte de la red. Para ubicar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta? ¿Necesita ayuda?

1-866-599-5426

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WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Employers
PORTADORA — EMPLEADOR

NOMBRE DEL PERSONA LESIONADA

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL — FECHA DE LA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	EMPLFF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

tmesys®

EMPLOYERS®

P.O. Box 32036, Lakeland, FL 33802-2036

EMPLOYERS® WAGE REPORT

It is necessary for us to determine the average weekly earnings of your employee named below who was injured in an accident while in your employment. Please complete and return the wage report below, which is required by your state's workers' compensation law.

Please fill in all the wages paid to the employee during the three (3) months before the accident, showing the number of days on which any work was done during each week, including part-time days. If the injured worker was not paid on a weekly basis, explain fully and give the earnings during the 13 weeks preceding the accident.

Employee	Claim Number:
Injury Date:	Wage Rate:
Disability Date:	Date Employed:

Week No.	Date From	Date To	Total Hours	Hourly Rate	Days Worked	Gross Pay Including Overtime
1					$	$
2					$	$
3					$	$
4					$	$
5					$	$
6					$	$
7					$	$
8					$	$
9					$	$
10					$	$
11					$	$
12					$	$
13					$	$

Totals			

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EMPLOYERS®

P.O. Box 32036, Lakeland, FL 33802-2036

What number of hours was a normal work day? _____

What number of days was a normal work week? _____

Did the employee receive any premium, bonus, board or lodging from you in addition to the wages listed above?

_____

_____

If so, please explain, stating amounts of value thereof _____

_____

_____

Did the employee do the same type of work during all of the time while employed by you during the year before the accident?

_____

_____

If not, please explain fully: _____

_____

_____

_____

_____

Once completed, please fax to EMPLOYERS at 800-371-8204.

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EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Fatal Injuries: Employers subject to ch.102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee.
Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department.
Electronic Reporting Requirement: All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to (608) 267-0394.

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
http://www.dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].
(**Please read the instructions on page 2 for completing this form**)

EMPLOYEE

Employee Name (First, Middle, Last)	Social Security Number*	Sex	Employee Home Telephone No.
	- -	☐ M ☐ F	( ) -

Employee Street Address	City	State	Zip Code	Occupation
			-	

Birthdate	Date of Hire	County and State Where Accident or Exposure Occurred?

EMPLOYER

Employer Name	WI Unemployment Ins. Acct No.	Self-Insured?	Nature of Business (Specific Product)
		☐ Yes ☐ No	

Employer Mailing Address	City	State	Zip Code	Employer FEIN
			-	-

Name of Worker's Compensation Insurance Co. or Self-Insured Employer	Insurer FEIN
	-

Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer	TPA FEIN
	-

WAGE INFORMATION

Wage at Time of Injury	Specify per hr., wk., mo., yr., etc.	In Addition to Wages, Check Box(es) if Employee Received:		
$	Per:	☐ Meals	☐ Room	☐ Tips
		No. of Meals/wk.	No. of Days/wk	Avg. Weekly Amt. $

Is Worker Paid for Overtime? ☐ Yes ☐ No If Yes, After How Many Hours of Work Per Week?

For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks.

No. of Weeks:	Gross Amount Excluding Tips: $	If Piece-Work, No. of Hrs. Excluding Overtime:

	Start Time	Hours Per Day	Hours Per Week	Days Per Week
Employee's Usual Work Schedule When Injured:	: ☐ AM ☐ PM			
Employer's Usual Full-Time Schedule for This Type of Work at Time of Employee's Injury:				

Part-Time Employment Information:	Are there Other Part-Time Workers Doing the Same Work With the Same Schedule? ☐ Yes ☐ No If yes, how many?	Number of **Full-Time** Employees Doing The Same Type Of Work:

INJURY INFORMATION

Injury Date	Time of Injury	Last Day Worked	Date Employer Notified	
	: AM : PM			☐ Date Returned to Work ☐ Estimated Date of Return

Did Injury Cause Death?	Date of Death	Was This a Lost Time or Other Compensable Injury?	Did Injury Occur Because of:		
☐ Yes ☐ No		☐ Yes ☐ No	☐ Substance Abuse	☐ Failure to Use Safety Devices	☐ Failure to Obey Rules

Was Employee Treated in an Emergency Room? ☐ Yes ☐ No Was Employee Hospitalized Overnight as an In-Patient? ☐ Yes ☐ No
Name and Address of Treating Practitioner and Hospital:
Case Number from the OSHA Log:

Injury Description - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved.

What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred)

What Was The Injury or Illness? (State the Part of Body Affected and How It Was Affected)

Report Prepared By	Work Phone Number	Position	Date Signed
	( ) -		

SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT

EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury will be returned to the sender if the mandatory information is not provided.

Employee Section: Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.