ODAFF
Employee Injury Reporting Procedures

Human Resource Department
2800 N. Lincoln Blvd
Oklahoma City, OK 73105
(405)522-5771

Table of Contents & Instructions

1. Network Provider information listed by county.
2. Workers Compensation Incident Investigation Report Form
    2.1.1. Employee or Supervisor will complete, p. 1.
    2.1.2. Supervisor will complete the investigation, p. 2.
3. Personal/Bodily Injury Standard Liability Incident Report (Non-Vehicle Injury).
    3.1.1. Employee will complete date and sign.
    3.1.2. Risk Management Coordinator will date and sign.
4. Scope of Employment.
    4.1.1. Employee will complete, date and sign.
    4.1.2. Supervisor will review, date and sign.
5. Gallagher Bassett (GB) Authorization for Release of Information form.
    5.1.1. Employee will complete date and sign.
6. Prescription information sheet and pharmacy list. Call ***866-445-7344*** to generate Member ID and Activation.
7. ODAFF WC Program Leave Option Election Work Related Accident /Illness
    7.1.1. Complete and return to HR with WC package. (if you are absent from work because of WC)
8. OPERS Application for Purchase of Delinquent Service. (OPERS Enrollment ONLY) Does not apply to Pathfinder Retirement.
    8.1.1. If employee elects to purchase the delinquent service time, it is the employees' responsibility to submit the request to HR.
9. ODOL 300 Questionnaire.
    10.1 Employee will complete.
10. Employee will forward Return to Work Status form; returned to HR after each medical visit.
    11.1 Medical provider will complete, date and sign.
    11.2 Employee forwards to Supervisor.
    11.3 Supervisor forwards to Human Resource Department.

*The claim cannot be submitted to Gallagher Bassett until HR receives the completed Workers Compensation Forms listed below; from the injured employee and supervisor.**

Table of Contents & Instructions

Return the below forms to the Human Resource Department as soon as possible and no later than 3 working days.

1. Workers Compensation Incident Investigation Report Form.
2. Personal/Bodily Injury Standard Liability Incident Report (Non-Vehicle Injury).
3. Scope of Employment.
4. Gallagher Bassett (GB) Authorization for Release of Information form.
5. ODAFF Leave Option Election Work Related Accident/Illness
6. OPERS Application for Purchase of Delinquent Service
7. ODOL 300 Questionnaire.
8. Return to Work Status form; returned to HR after each medical visit

After your claim has been submitted to Gallagher Bassett you will be assigned one of the below claims adjusters within approximately 5 working days. If you have any question or concerns regarding your claim please contact your assigned adjuster.

Trent Voth	405-415-8304	Trent_Voth@gbtpa.com
Kathy Wigley	405-415-8309	Mary_Wigley@gbtpa.com
Twana Brinlee	405-415-8308	Twana_Brinlee@gbtpa.com
Michael Baxter	405-415-8307	Michael_Baxter@gbtpa.com
Elaine Howard	405-415-8311	Elaine_Howard@gbtpa.com
Bradley Morrisett	405-415-8305	Bradley_Morrisett@gbtapa.com

PeopleSoft Workers Compensation Leave Codes

WCANP – Workers Comp An Lv Hrs Pd
WCCT1 – Workers Comp Comp Time Hrs Pd
WCSKP – Workers Comp Sick Lv Hrs Pd
WCWOH– Workers Comp Without Pay Hours

If you receive a bill in the mail, make a copy and mail original to:

Gallagher Bassett Services, Inc.
PO Box 2831
Clinton, IA 52733-2831

To Find Gallagher Bassett Managed Care

Services Network Providers

Website: www.talispoint.com/gb/gbcare1

Search by:

- Address
- Zip or city/state
- Specify the types of providers, e.g. First Treatment providers, Occupational Medical Clinics, etc.
- Providers who are in our preferred Outcomes Based Network (OBN) are listed first, with a torch icon before their names.

OR

- Call the dedicated GB Info Line for WC:

1-800-370-0594, Option 6

State of Oklahoma

WORKERS' COMPENSATION INCIDENT INVESTIGATION REPORT

Check Box: ☐ INJURY ☐ ILLNESS ☐ NEAR MISS

Email completed form to: tnwclaims@tnwinc.com or fax to: 800-748-6159

A. EMPLOYEE INFORMATION: ALL FIELDS REQUIRED

EMPLOYEE'S NAME		M/F	DOB	COMPLETE SSN	JOB TITLE/CLASSIFICATION	
EMPLOYEE ID NUMBER	FT ☐ Temp ☐	Seasonal ☐	DATE OF INCIDENT	DATE OF HIRE	TIME WORK DAY BEGAN	TIME OF INCIDENT (AM / PM)
AGENCY # 040 040	DEPT	OVERTIME? Y ☐ N ☐	SHIFT? 1 ☐ 2 ☐ 3 ☐	HAS EMPLOYEE LOST TIME FROM WORK? ☐ Yes ☐ No	HAS EMPLOYEE RETURNED TO WORK? ☐Yes ☐No If yes, what date?	
AVERAGE WEEKLY WAGE	AT THE TIME OF THE INCIDENT THE EMPLOYEE WAS: ☐ on break ☐ on lunch ☐ arriving/leaving work for the day ☐ performing the following task or tasks:					
EMPLOYEE'S HOME ADDRESS		EMPLOYEE'S PHONE # Home & Cell & EMAIL		SUPERVISOR'S NAME, PHONE # & EMAIL		

B. INCIDENT DETAILS: Is there any reason to question how this incident occurred? ☐Yes ☐No Explain:

LOCATION/ADDRESS (where injury occurred):	DESCRIBE WHAT HAPPENED:

C. WAS MEDICAL TREATMENT REQUIRED? ☐ Yes ☐ No

1. If yes, what type of treatment and where was it received?
2. Is there a follow up appointment and if so, when is it?
3. Was employee put on restricted duty?
4. Can restricted duty be accomodated?

D. PART OF BODY INVOLVED (be specific: left, right, upper, lower, etc.)

E. TYPE OF INCIDENT

☐ Caught on or in	☐ Ingestion	☐ Inhalation	☐ Fall-same level	☐ Bitten
☐ Overexertion	☐ Electrical	☐ Chemical – skin	☐ Fall-different level	☐ Lifting
☐ Struck by/against	☐ Slip or Trip	☐ Explosion	☐ Heat/Cold exposure	☐ Cut
☐ Auto accident	☐ Cumulative injury	☐ Puncture	☐ Other _____	

F. WITNESS TO INJURY (attach witness statement to investigation page 2)

NAME #1:	PHONE #	NAME #2:	PHONE #

G. FORM COMPLETED BY:

Print Name & Title	Phone # & Email Address	Date & Time Injury Reported to Agency
		a.m./p.m.
		a.m./p.m.

H. SUPERVISOR'S INVESTIGATION OF INCIDENT

WHAT HAPPENED? (Be specific; include heights, weight, repetitions, dimensions, lighting etc.)

I. WHY DID IT HAPPEN?

ROOT CAUSE #1:

ROOT CAUSE #2:

ROOT CAUSE #3:

J. WHAT CORRECTIVE ACTION IS BEING TAKEN TO ELIMINATE POTENTIAL FOR FURTHER INJURY OR ILLNESS?

What specifically is being done? How are we addressing root causes, behavior, hazards, training?

K. DISCIPLINARY ACTION TAKEN: ☐ YES ☐ NO

Describe:

L. FALL FROM DIFFERENT LEVEL INFORMATION:

Height:	Was a ladder involved? Describe:

M. CAUSE OF INCIDENT – UNSAFE ACT: ☐ BY INJURED PERSON -or- ☐ BY OTHER PERSON (NAME):

☐ Failure to warn or signal	☐ Working/reaching moving equipment	☐ Overloading equipment or containers
☐ Making safety devise inoperative	☐ Failure to shut off or lockout	☐ Wearing unsafe attire, jewelry etc.
☐ Not observing where walking or driving	☐ Moving objects too heavy	☐ Disregard instructions
☐ Operating at unsafe speed	☐ Not wearing PPE	☐ Horseplay
☐ Operating without safety device	☐ Operating without authority	☐ Lack of training
☐ Taking unsafe position	☐ Using unsafe tools or equipment	☐ No unsafe act
☐ Negligence	☐ Employee misconduct	☐ Other_____

N. CAUSE OF INCIDENT – UNSAFE CONDITION

☐ Hazardous arrangement	☐ Poor Housekeeping	☐ Wet/slippery/icy floor or ground
☐ Insufficient lighting	☐ Unsafe design	☐ Other _____
☐ Insufficient guarding	☐ Ergonomic deficiency	☐ Other _____
☐ Faulty machine or equipment	☐ Hazardous work method	☐ Other _____
☐ Insufficient ventilation	☐ Poor air quality	☐ Other _____

O. CAUSE INFORMATION

YES	NO	
1. ☐	☐	Was employee doing his/her regularly assigned job? Explain a "no" answer below.
2. ☐	☐	Did you (supervisor) provide proper instruction on how to do the job safely? Explain a "no" answer below.
3. ☐	☐	Was employee doing this job as you had instructed? Explain a "no" answer below.
4. ☐	☐	Was proper equipment provided? Explain a "no" answer below.
5. ☐	☐	Was the employee using the equipment? Using it properly? Explain a "no" answer below.
6. ☐	☐	Have you had similar incidents with this or other equipment in you area? Explain a "yes" answer below.

Additional comments from above:

P. SAFETY INVESTIGATION AND FOLLOW-UP

YES	NO	
☐	☐	Was the investigation thorough?
☐	☐	Was corrective action taken?
☐	☐	Did the supervisor make every attempt to help eliminate the unsafe act or hazard?
☐	☐	Did the employee make every attempt to help eliminate the unsafe act of hazard?

Explanation and recommendations:

Q. INVESTIGATION COMPLETED BY:

Print Name & Title	Phone # & Email Address	Date Completed

State of Oklahoma
Office of Management and Enterprise Services
Division of Capital Assets Management
Risk Management Department

Personal/Bodily Injury Standard Liability Incident Report (Non-Vehicle Injury)

DCAM-RISK MGMT P.O. BOX 53364 OKLAHOMA CITY, OKLAHOMA 73152 TEL: 405/521-4999 (24h), FAX: 405/522-4442

Claim Form Requested? ☐ Yes ☐ No **Claim Number** _____

Incident Date: _____ Time: _____ **Date of Agency Notification:** _____

Location:

_____ _____ _____ _____
Address/Highway City State County

Describe Incident:

Photos of accident scene and location need to be taken.

Was Employee Aware of Incident? ☐ Yes ☐ No

Claimant's Information:

Claimant's Name: _____ Phone: ( ) -

Address: _____ City: _____ State: _____ Zip Code _____

Email Address: _____

Was the Claimant Injured? ☐ Yes ☐ No

Describe: _____

Name of Doctor or Hospital: _____

Agency Information

Agency Name: _____ Agency # _____ Phone: ( ) -

Type of Employment: ☐ Full Time ☐ Temporary ☐ Volunteer ☐ Contract

Employee Name: _____ Job Title: _____

Div. or Dept. _____ Address: _____ Phone: ( ) -

Witnesses:

Name	Address	Phone

Claim Number

Slip and Fall

Was the person distracted? ☐ Yes ☐ No If so, by what? _____
How did the person fall? ☐Forward ☐Backward ☐ Other _____
What part(s) of the body was injured? _____
Was the person talking to someone? ☐ Yes ☐ No Were there children present? ☐ Yes ☐ No
Was the person a client of the place where the incident occurred? ☐ Yes ☐ No
Was the surface wet, oily, dirty, slippery, etc.? ☐ Wet ☐ Oily ☐ Slippery ☐ Dirty ☐ Other _____
Were danger or caution signs posted? ☐ Yes ☐ No If so, what? _____
Was there a transition in walkway surfaces, or any tripping hazards? If so, explain _____
Was weather (rain/snow) a factor in the incident? If so, describe _____
Was site cleanup needed? (spill, dirt, etc.)? ☐ Yes ☐ No Describe _____
How long after first notice was incident cleaned up? _____
Type of footwear worn? ☐ athletic shoes ☐sandals ☐ high heels ☐ flats ☐ other _____
Type of material of shoe heel? ☐rubber ☐ leather ☐ synthetic ☐ other _____
Did footwear contribute to the fall? ☐ Yes ☐ No Explain _____

Machinery Incidents

Was injury due to machinery? ☐ Yes ☐ No If so, who was operating? _____
What type of machinery was involved in the incident? _____
Policy/procedure regarding operation of machinery? ☐ Yes ☐ No Operator trained? ☐ Yes ☐ No
Machinery last service date? _____ Machinery last safety inspection? _____
Were safety features in place? (guards, chains etc?) ☐ Yes ☐ No Explain _____

General Questions

Type of terrain? (i.e. flat, hilly, grassy gravel?) _____
Area inspected/cleared of debris and safety hazards? _____
Did you speak to a witness? ☐ Yes ☐ No If so, what was said? _____
Was assistance provided? ☐ Yes ☐ No If so, what? by whom? _____
Was any non-medical personnel called to accident site? If so, who? _____
Was the incident reported to local authority? ☐ Yes ☐ No If so, provide police report.

Attach additional sheet, if needed

By signing this form you are attesting the information contained is accurate.

Employee Signature	Date	Risk Coordinator Signature	Date

Employee Name Printed	Coordinator Name Printed

State of Oklahoma
Office of Management and Enterprise Services
Division of Capital Assets Management
Risk Management Department

Scope of Employment

DCAM-RISK MGMT P.O. BOX 53364 **OKLAHOMA CITY, OKLAHOMA 73152** **TEL: 405/521-4999, FAX: 405/522-4442**

Incident Date _____ Time _____ Claim No (DCAM use only): _____

Employee Name _____ Job Title: _____

State Agency Name _____ Agency Number _____

Division or Dept _____ Phone _____

Address _____ City _____ State _____ Zip _____

Type of Employment: ☐ Full Time ☐ Temporary ☐ Volunteer ☐ Contract

Who Authorized This Specific Duty? _____

Was employee aware of incident? ☐ Yes ☐ No

Please describe in detail what specific duty was being performed at the time of the incident.

Employee Signature	Supervisor Signature
Employee Name Printed	Supervisor Name Printed
Date	Date

Occupational Injury Temporary Prescription ID Card

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved work-related injury prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx Patient Care Contact Center at 844-276-2515.

Atención Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 844-276-2515.

To the Pharmacist:

myMatrixx, an Express Scripts company administers this occupational accident prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 30-day supply or a cost of $500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx at 844-276-2515.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

myMatrixx, an Express Scripts Company

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____ / _____ / _____
MM/DD/YYYY

Group #: NZEA

Employee Date of Birth: _____ / _____ / _____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor:

Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

006405 State of Oklahoma

CRP1806_0245 EME46657 OT48016Y

Participating Retail Network Pharmacies

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

GALLAGHER BASSETT SERVICES, INC.
AUTHORIZATION FOR RELEASE OF INFORMATION
(HIPAA COMPLIANT)

Patient Information:

_____ DOB: _____ SS#: _____
(Print Name of Patient)

Information to be released from: _____
Name of Designated Facility or Provider

_____
Address

_____ _____
City, State, Zip Code Phone Number

Additional facility or provider: _____
Name of Designated Facility or Provider

_____
Address

_____ _____
City, State, Zip Code Phone Number

Information to be sent to:

GALLAGHER BASSETT SERVICES, INC.
ATTN: _____
Name of Designated Recipient

_____
Address

_____ _____
City, State, Zip Code Phone Number

Information to be released:

- ☐ The most recent 2 years of pertinent information (chart notes, labs, X-rays and special tests)
- ☐ All medical records
- ☐ Medical Billing
- ☐ Specific information (Please specify) _____

Purpose for which disclosure is being made:

Processing of an insurance claim.
Date of Loss:

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

*** EXCLUDE the following information from the records released (please initial):**

☐ Drug/Alcohol abuse /treatment & diagnosis

☐ HIV/AIDS diagnosis/treatment/ testing

☐ Sexually Transmitted Disease

☐ Mental Illness or psychiatric diagnosis/treatment

My Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE: _____ DATE: _____
(Patient, Guardian*, or Authorized Representative*)
[*Please provide documents to prove authority to sign on behalf of the patient]

SHALL BE VALID FOR ONE YEAR FROM THE ABOVE DATE
PHOTOCOPY VALID AS ORIGINAL

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. `Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Oklahoma Department of Agriculture, Food and Forestry

Workers' Compensation Program
Leave Option Election
Work Related Accident/Illness

Employee Name	SSN	Classification
Division	Date of Accident/Illness	Workers' Comp Claim #

In accordance with Section 2e of Title 85 of the Oklahoma Statutes, an employee suffering from a work-related accident or illness may supplement his or her Workers' Compensation Temporary Total Disability (TTD) with the use of any available sick or annual leave to the extent that he or she receives the equivalent of full wages during the absence from work.

The first three calendar days of absence will **NOT** be compensated by Workers' Compensation, regardless of the leave election for that period of time. When leave is used to supplement Workers' Compensation leave without pay, a separate warrant is prepared for that time and issued on a supplemental payroll.

Leave Option Election

For the First Three calendar days of absence, I elect to use:

Annual Leave ☐ Comp Time☐ Sick Leave☐ Leave Without Pay☐ Shared Leave☐

For the remainder of my absence, I elect to use:

- **Only Leave Without Pay**. This will not supplement my TTD payments.☐
- A combination of paid leave as indicated below. This will enable me to supplement my TTD payments. I have numbered my election(s) below in the order I wish to use them.

  Annual leave until exhausted _____
  Regular comp time until exhausted _____
  Sick leave until exhausted _____
  Comp holiday until exhausted _____
  Shared leave, if eligible _____

Note: Any Person receiving temporary disability benefits from any employer or the employer's insurance carrier, must promptly report in writing to the employer or insurance carrier, any change in a material fact, or the amount of income he or she is receiving, or any change in the employment status, occurring during the period of receipt of such benefits.

I have read and understand this from and I hereby elect the above options for leave adjustments(s) to be made during my absence. I understand that this election may be changed by submitting a new Leave Option Election – Work-related Accident/Illness form. This leave option election is effective with the pay period in which it is received.

_____ _____
Signature of Employee Date

Issued 2/28/2019

Application for Purchase of Delinquent Service

515-143-11
24

This form is to be completed only by the Retirement Coordinator of a participating employer of OPERS. Use this form to certify employment during which an employee did not participate in OPERS, but may have been eligible to do so. If you need additional space, use a separate form.

PART 1 – MEMBER INFORMATION

Name (First, Middle, Last)

Social Security number

Agency name

Agency number

This form will be incomplete if employment status is not indicated. Check one: ☐ permanent ☐ temporary ☐ seasonal

PART 2 – DELINQUENT SERVICE INFORMATION

Provide the member's gross salary and number of hours worked for each period of delinquent service.

Pay period End date	Gross salary	Number of hours worked

Pay period End date	Gross salary	Number of hours worked

PART 3 – RETIREMENT COORDINATOR CERTIFICATION

"Any person who shall knowingly make any false statement, or who shall falsify or permit to be falsified any record necessary for carrying out the intent of this act for the purpose of committing fraud, shall be guilty of a misdemeanor, and upon conviction shall be punished by a fine not exceeding Five Hundred Dollars ($500.00) or by imprisonment for not exceeding one (1) year." 74 O.S. §924

I certify that the above employee information is correct according to the records of this participating employer.

Retirement Coordinator's signature

Date

OKLAHOMA PUBLIC EMPLOYEES RETIREMENT SYSTEM
P.O. Box 53007 | Oklahoma City, Oklahoma 73152-3007
Tel 405-858-6737 | Toll-free 1-800-733-9008 | www.opers.ok.gov

Rev. 8/2011