# PROVIDER NOTIFICATION OF A WORK-RELATED INJURY OR OCCUPATIONAL DISEASE

This form shall act as notification for workers' compensation insurance coverage. This form is to be presented to the physician's office, hospital emergency department, or other authorized provider that is treating you for your work-related injury.

This notice is to inform you that _____
**(Injured employee's name)**

has claimed a work-related injury or occupational disease that occurred on _____.
**(Date of injury)**

This employee's injury or occupational disease may be covered by Workers' Compensation Insurance through the University of Texas System. All claims are handled by CCMSI. This form does not certify compensability or guarantee payment. Do Not use employees' personal health insurance. It is an administrative violation to bill the injured employee directly for workers' compensation treatment.

| | |
|---|---|
| **For Workers' Compensation consideration**<br><br>**Please submit all bills and medical reports, or questions to:** | **The University of Texas System c/o CCMSI**<br>**Cannon Cochran Management Services, Inc.**<br>**P. O. Box 802082**<br>**Dallas, Texas 75380**<br><br>**Phone: 1.888.396.6844**<br>**FAX: 217.477.6813** |
| **For Provider Referrals** | **Injury Management Organization (IMO)**<br><br>**214.217.5939 or 888.466.6381**<br>**FAX: 214.217.5937 or 877.946.6638**<br>**Email: CSRNetwork@injurymanagement.com** |
| **For Preauthorization Request** | **888.645.1200 or 972.404.8133**<br>**Fax: 888.275.9946** |

_____ _____
**Supervisor or Authorized Department Delegate** **Date**

# The University of Texas at Arlington

## Workers' Compensation Network Acknowledgement Form

I have received information (Notice of Network Requirements & Employee Handbook Material) which informs me how to get Health Care under Workers' Compensation Insurance.

If I am hurt on the job and live in the service area described in this information, I understand that:

1. I must choose a treating doctor from the list of physicians in the ***IMO Med-Select Network®.*** (A list of physicians can be found at www.injurymanagement.com) Or, I may ask my HMO primary care physician to agree to serve as my treating doctor by completing the Selection of HMO Primary Care Physician as Workers' Compensation Treating Doctor Form # IMO MSN-5.
2. I must go to my network treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
3. The insurance carrier will pay the treating doctor and other network providers.
4. I *may have to pay* the bill if I get health care from someone other than a network doctor without network approval.
5. If I receive the Notice of Network Requirements and refuse to sign the Acknowledgement Form, *I am still required to use the network*.

Please fill out the following information before signing and submitting this completed acknowledgement form. Injury Management Organization may contact you via phone, email and/or text to provide information to you and/or discuss your work injury.

**Name of Carrier:** The University of Texas System **Name of Network:** IMO Med-Select Network®

**Home Address**:_____

**Street Address – No P.O. Box or Work Address**

_____

**City** **State** **Zip Code** **County**

_____ _____ _____

**Printed Name** **Date of Injury** **Employee Phone Number**

_____ _____ _____

**Employee Signature** **Date** **Email**

For more information please contact the office of Environmental Health & Safety at (817) 272-2185

UNIVERSITY OF TEXAS ARLINGTON

Environmental Health and Safety

Form CO-EHS-F401
11/2023

# University of Texas at Arlington

## Employee's Report of Work-Related Injury or Occupational Disease

***Personal Information:***

Employee Name: _____ UT EID: _____ Email Address: _____

Home Phone: _____ Mailing Address: _____ City: _____Zip: _____

Work ext. or best number to reach you during working hours: _____

Date of Birth: _____ ☐ Male ☐ Female Race: ☐ Black ☐ White ☐ Asian ☐ NA

Marital Status: ☐ Married ☐ Unmarried ☐ Separated Spouse's Name: _____ ☐ NA # Dependent Children? _____ ☐ NA

Position/Title: _____ Department Where Employed: _____

***Incident Information:***

Date of Injury: _____ Time of Injury: _____ ☐ a.m. ☐ p.m. Date Supervisor was notified: _____

Direct Supervisor's Name: _____ Direct Supervisor Contact Number: _____

Name of management you reported the injury to, if different than direct supervisor: _____

Contact Number: _____

Worksite location of injury (Ex.: Administration Bldg., Sidewalk, Corridor by 2nd floor elevators, Lab, etc.)

Building/Room#_____ Description of Area_____

If off campus, location and physical address: _____

Describe below how the injury or exposure occurred. (Ex.: I left my office walking to the elevator, my shoe caught on carpeted hallway, and I tripped/fell striking right shoulder on floor OR I struck the top of my left hand with a screwdriver while trying to put together a desk for my office.)

Describe the resulting 'physical' injury (s) (Ex.: sprained left ankle, bruised left shoulder, laceration on top of head)

Did anyone witness the injury? Yes ☐ No ☐ List witness name (s) and contact information below.

1. _____ Contact # or email _____

2. _____ Contact # or email _____

3. _____ Contact # or email _____

**Please select all body parts where you were injured and check the appropriate boxes.**

| | Left | Right | Both | | | Left | Right | Both |
|---|---|---|---|---|---|---|---|---|
| **Abdome/Stomach** ☐ | ☐ | ☐ | ☐ | | **Head** ☐ | ☐ | ☐ | ☐ |
| **Ankle** ☐ | ☐ | ☐ | ☐ | | **Hip** ☐ | ☐ | ☐ | ☐ |
| **Arm** ☐ **upper** ☐ **lower** ☐ | ☐ | ☐ | ☐ | | **Knee** ☐ | ☐ | ☐ | ☐ |
| **Back** ☐ **upper** ☐ **lower** ☐ | ☐ | ☐ | ☐ | | **Leg** ☐ **upper** ☐ **lower** ☐ | ☐ | ☐ | ☐ |
| **Buttocks** ☐ | ☐ | ☐ | ☐ | | **Multiple Body Parts** ☐ | ☐ | ☐ | ☐ |
| **Chest (includes ribs/sternum)** ☐ | ☐ | ☐ | ☐ | | **Neck** ☐ | ☐ | ☐ | ☐ |
| **Ear** ☐ | ☐ | ☐ | ☐ | | **Nose** ☐ | ☐ | ☐ | ☐ |
| **Elbow** ☐ | ☐ | ☐ | ☐ | | **Sacrum/Coccyx Tailbone** ☐ | ☐ | ☐ | ☐ |
| **Eye** ☐ | ☐ | ☐ | ☐ | | **Shoulder** ☐ | ☐ | ☐ | ☐ |
| **Face** ☐ | ☐ | ☐ | ☐ | | **Throat** ☐ | ☐ | ☐ | ☐ |
| **Foot** ☐ | ☐ | ☐ | ☐ | | **Teeth** ☐ | ☐ | ☐ | ☐ |
| **Hand** ☐ | ☐ | ☐ | ☐ | | **Wrist** ☐ | ☐ | ☐ | ☐ |
| **Finger thumb** ☐ **index** ☐ **middle** ☐ **ring** ☐ **little (pinky)** ☐ | | | | | **Toe 1st** ☐ **2nd** ☐ **3rd** ☐ **little toe** ☐ **great toe** ☐ | | | |

## ***Medical Information:***

Please complete and return the Workers' Compensation Network Acknowledgement Form which informs you how to get healthcare under workers' compensation insurance. Please review the Notice of Network Requirements and obtain the WC Pharmacy First Fill /Text2Fill form.

I have been offered medical treatment but do not wish to receive any now. Initials_____
I understand this does not prevent me from seeking medical treatment later.

If seeking initial medical treatment, please provide the information below:

_____
Clinic or Hospital Name

_____
Physician

_____
Phone

_____
Address of clinic:

The above statement is true and accurate to the best of my knowledge. I confirm that the accident described above happened while I was performing duties that were assigned to me by UTA (University of Texas Arlington).

I understand that information related to the incident, including the nature of the injury or occupational disease, may be shared with the Environmental Health and Safety and/or other UTA/UT System depts. for improvements in workplace safety and preventing accidents and injury. It may also be shared with Office of Talent, Culture, and Inclusion for designation of Family Medical Leave, if applicable.

Injured Employee's Signature_____ Date _____

**Scan and email completed form to workerscompensation@uta.edu.**

UNIVERSITY OF TEXAS ARLINGTON

# Environmental Health and Safety

Form CO-EHS-F402
11/2023

## Supervisor's Report of Employee Work-Related Injury or Occupational Disease

***Personal Information:***

Name of Injured Employee: _____ Employee Extension: _____ Does not have personal extension □

What is the best number to contact employee? _____

Does your injured employee speak English? Yes □ No □ If no, what language? _____

***Job Information:***

Employee's Position/Title: _____ Dept. Where Employed: _____

Length of service in current position:_____ Employee's normal work week (Ex.: Mon-Fri, 7am - 4pm, no lunch) _____

*Please provide the current leave balances as of the date of injury. Sick:* _____ *Vacation:* _____ *Compensatory:*_____

***Incident Information:***

Date of Injury: _____ Time of Injury: _____ a.m. □ p.m. □

When were you notified about this injury? Date: _____ Time: _____ a.m. □ p.m. □

Are you the employee's direct supervisor? Yes □ No □ If no, who is the direct supervisor? _____

Has your employee missed a full workday(s) because of this injury (excluding the day of injury)? Yes □ No □

Excluding the day of injury, what was the first scheduled workday missed? _____ N/A □

Return to work date (if known):_____

Worksite where injury happened (Ex: Administrative Bldg., Sidewalk, 2nd floor elevators, Lab):

Building/Room # _____

Description of Area _____

Based on your inquiry, what was your employee doing at the time of the injury. *(Ex.: "The employee stated he was walking into the building, slipped on the wet tile and fell to his knees causing a bruise to his left knee").*

When the injury happened, was your employee performing their regular duties or a specific task assigned to them? Yes □ No □

If no, please describe what they were doing at the time of the reported injury.

Was there physical evidence of injury to the claimed body parts? Yes □ No □ N/A □

If yes, please describe (Ex.: scratch on upper left arm, cut to top of head/scalp, bruised right knee)

Were there any witnesses to this injury? Yes □ No□ If yes, list name(s) and phone number(s). Attach an additional sheet, if necessary.

1. _____ Contact # or email _____

What do you think may prevent this type of accident from happening in the future?

***Medical Information:***

Did you provide the employee the required WC Network Acknowledgement form & Notice of Network Requirements packet on how to get healthcare under workers' compensation insurance? Yes □ No □

Initial Medical Treatment: Yes □ No □ First Aid Only Yes □ No □ Physician/Treatment Facility Yes □ No □ ER Visit Yes □ No □

Supervisor's Signature: (**Required):** _____Date: _____

Print Supervisor's Name: _____Ext._____Supervisor's Email Address: _____

This form was completed by ***(if other than the supervisor)***:

Print Name _____ Ext: _____Email Address: _____

**Scan completed forms and email to workerscompensation@uta.edu**

***Please be aware that signing this report is not an admission by or evidence against UT Arlington. The information contained in this report only documents the supervisor's knowledge or version of how this incident occurred.***

**(You may be entitled to know what information The University of Texas at Arlington (UT Arlington) collects concerning you. You may review and have UT Arlington correct the information according to procedures set forth in UTS 139. The law is found in sections 552.021, 552.023 and 559.004 of the Texas Government Code.)**

**Revised: 11/23**

# Workers' Compensation Program

IMO Med-Select Network is the network in which you will use to gain access to medical care for your injury. For emergency care you may seek treatment at the nearest emergency facility.

The following is a partial list of clinics near campus.

**Care Now**
5405 S. Cooper
Arlington, 76017
817-465-4928

**Care Now**
8450 Eastchase
Fort Worth, 76120
817-459-2005

**Care Now**
2520 W. I-20
Grand Prairie, 75052
972-264-5858

**Concentra**
2160 E. Lamar Blvd.
Arlington, 76006
972-988-0441

**Concentra**
511 E. I-20
Arlington, 76018
817-261-5166

**Concentra**
2500 W. Freeway (I-30)
Ft. Worth, 76102
817-882-8700

**Concentra-West**
5900 I-20 W
Arlington, 76017
682-226-6001

**Concentra**
2045 N Hwy 360 Ste 100B
Grand Prairie, 75050
972-623-1111

**Concentra Telemed**

**Fit Temple 365**
1241 W. Green Oaks Blvd.
Arlington, 76013
817-704-3365

**Baylor Scott & White Urgent Care**
4401 Little Road Ste. 520
Arlington, 76016
682-318-3114

RxBridge

# THE UNIVERSITY OF TEXAS AT ARLINGTON
# FIRST FILL PRESCRIPTION CARD

Upon receiving prescriptions for a work-related injury for one of your employees, please provide the injured worker with a copy of this instruction sheet or ask them to text **UTA00** to toll free 833-FRSTFILL (833-377-8345). The injured worker will complete the process and then present their billing information via mobile device.

Please follow the below instructions to obtain your First Fill Prescription Card.

**Text**

**UTA00**

**to 833-377-8345**

## How it Works

**01**

**Text**

Text **UTA00** to toll free
833-FRSTFILL (833-377-8345)

**02**

**Follow the On-Screen Step by Step Instructions**

**Step 1:** Text your First and Last Name
**Step 2:** Text your Date of Injury
**Step 3:** Confirm Information

**03**

**Receive First Fill Card**

You will receive an image of your prescription card right to your phone.

**04**

**Fill Your Prescriptions**

Present your First Fill Prescription Card along with your injury related prescription(s) to your local pharmacy.


If you encounter any problems filling your prescriptions or to find a participating retail pharmacy, please call RxBridge at 833-RxBridge (833-792-7434) or use our pharmacy locator at www.RxBridge.com