

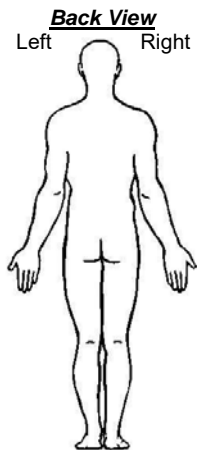
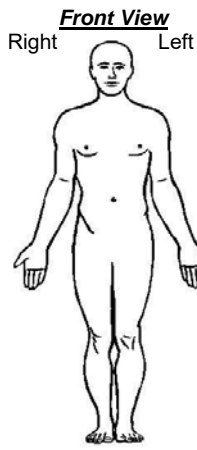
The University of Texas System
Employee's First Report of Work-Related Injury or Occupational Disease

Employee Information		
Injured Employee's Name: _____ Male () Female () Date of Birth: ___/___/_____		
Home/Cell Phone: (____) _____ Work Phone: (____) _____ Preferred Language: _____		
Employee ID: _____ Race: Asian () Black () White () Other () Ethnicity: Hispanic () Native American () Other ()		
Work Email Address: _____ Personal Email Address: _____		
Home Address: _____ City: _____ State: _____ Zip: _____		
Marital Status: Married () Single () Widowed () Spouse's Name: _____ () NA # of dependent children? ___ () NA		
Position/Title: _____ Employing Department: _____ Full Time () / Part Time ()		

Incident Information		
Location where this occurrence happened? (Please be specific.) _____		
Address or name of building / location where this occurrence happened? _____		
Date of occurrence: _____ Time of occurrence: _____ () AM () PM Did you notify your supervisor? () Yes () No		
Date Supervisor Notified: _____ Time _____ () AM () PM Name of Supervisor: _____		
Were there any witnesses to this occurrence? () Yes () No _____ (____) _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Witness Name Phone </div>		
Did you seek medical treatment for this occurrence? () Yes () No If Yes, List name, phone and address of hospital / physician: _____		
*Employees who live in the network service area must seek medical attention from any physician or clinic within the Workers' Compensation Provider Network		
Were days lost from work due to occurrence (not including injury date)? () Yes () No		
Have you returned to work? () Yes () No, Date Returned: ___/___/_____		

Please mark the areas of the body picture below that reflect where you were injured and check the appropriate boxes to the left.

- () Back
- () Head
- () Face
- () Neck
- () Shoulder
- () Arm
- () Wrist
- () Hand
- () Finger(s)
- () Chest
- () Abdomen
- () Ribs
- () Hips
- () Buttocks
- () Thigh
- () Knee
- () Leg
- () Ankle
- () Foot
- () Other



Describe in detail the nature of your injury or occupational disease and how it happened (if more space needed, write on back of sheet) <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

The above statement is true and accurate to the best of my knowledge. I confirm that the occurrence described above happened while I was performing my essential job duties that were assigned to me by The University of Texas System Administration and my employing department.

Injured Employee's Signature	Date	Extension
Supervisor's Signature	Date	Extension

Please email the completed First Report of Injury and completed IMO Network Acknowledgement form to Workers' Compensation @ bholman@utsystem.edu.

The University of Texas System Administration



Workers' Compensation Network Acknowledgement Form

I have received the Notice of Network Requirements 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:

Name of Carrier: The University of Texas System

Employee ID #: _____ **Name of Network:** IMO Med-Select Network[®]

Hire Date: _____ **Department:** _____

Home Address: _____

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

City

State

Zip Code

County

Employee Signature

Date

Printed Name

Employee Phone Number

The University of Texas System Administration

Provider Notification of an on-the-job injury

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

If you have any questions regarding your workers' compensation coverage, please contact the Office of Risk Management at 512-499-4645

Employee Name:											
Date of Birth:	Date of Injury:										
Provider Instructions											
<p style="text-align: center;"><u>PLEASE COPY THIS FORM AND RETURN TO EMPLOYEE</u></p> <p>This employee has claimed a work related injury and may be covered by Workers' Compensation Insurance through the University of Texas System.</p> <p>The University of Texas System Administration is a self-funded employer. Claims are processed through the University of Texas System in Austin.</p> <p>It is an administrative violation to bill injured employee directly for Workers' Compensation treatment. See Section 413.042 of Texas Labor Code.</p> <p>Pre-Authorization: For pre-authorization, please call 214-217-5939 or toll-free 888-466-6381 or fax to 214-217-5937 or 877-946-6638.</p> <p style="text-align: center;"><i>THIS FORM DOES NOT CERTIFY COMPENSABILITY OR GUARANTEE PAYMENT</i></p>	<p style="text-align: center;">Please submit bills, medical reports, or questions to:</p> <div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>The University of Texas System c/o CCMSI Cannon Cochran Management Services, Inc P.O.Box 802082 Dallas, TX 75380 PHONE: 1-888-802-0692 FAX: 217-477-6813 E-mail: UTS@CCMSI.com</p> </div>										
Pharmacy Instructions											
<p>The University of Texas System has partnered with Mitchell ScriptAdvisor to make filling prescriptions easy.</p> <p>Please use this form as a temporary prescription card. Please process prescriptions for the workers' compensation injury only. This form is only valid if signed and dated by at UT employer representative.</p> <p>For questions or rejections, please call 877-232-6520. Please DO NOT send employee home or have employee pay for medication(s) before calling Mitchell for assistance.</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">Processor: Mitchell</td> <td style="width: 50%; padding: 5px;">PCN: MPS</td> </tr> <tr> <td style="padding: 5px;">Group: MPS001150TC</td> <td style="padding: 5px;">BIN: 019082</td> </tr> <tr> <td colspan="2" style="padding: 5px; text-align: center;">Mitchell Help Desk: 877-232-6520</td> </tr> <tr> <td colspan="2" style="padding: 5px;"> ID: _____ Date of injury (MMDDYY)+Date of Birth (MMDDYY) <i>(ID Example: MMDDYYMMDDYY)</i> </td> </tr> <tr> <td colspan="2" style="padding: 5px;">Day Supply is limited to 7 days for a new injury</td> </tr> </table>	Processor: Mitchell	PCN: MPS	Group: MPS001150TC	BIN: 019082	Mitchell Help Desk: 877-232-6520		ID: _____ Date of injury (MMDDYY)+Date of Birth (MMDDYY) <i>(ID Example: MMDDYYMMDDYY)</i>		Day Supply is limited to 7 days for a new injury	
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Day Supply is limited to 7 days for a new injury											
<p>Injured Employee:</p> <p>PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS</p> <p>Please feel free to contact the Office of Risk Management at 512-499-4645 to assist you in locating a workers' compensation treating medical provider.</p> <p>Please take this form and your prescription(s) to a local pharmacy. Mitchell has a network of pharmacies nationwide. If you need assistance in locating a pharmacy near you, please call Mitchell toll-free at 877-232-6520 or use the "Find a Pharmacy" search tool at https://www.mitchell.com/products-services/pharmacy-solutions/scriptadvisor.</p> <p>If you are denied medication(s) at the pharmacy, please call 877-232-6520.</p>											
MODIFIED DUTY MAY BE AVAILABLE, PLEASE REACH OUT TO YOUR SUPERVISOR											

Employer Representative

Phone

Date