DEPARTMENT OF CONSUMER & BUSINESS SERVICES *Workers' Compensation Division*

**Worker's and Health Care Provider's Report for Workers' Compensation Claims**

# Provider instructions

| The worker completes<br>the worker section of this form for the following: | The worker does **NOT** complete<br>the worker section of this form if the provider chooses to use it for the following: |
|---|---|
| • First report of injury or disease<br>• Request for acceptance of a new or omitted medical condition<br>("Omitted" refers to a condition the worker thinks should have been included among the conditions accepted by the insurer.)<br>**If the worker checks this box, it initiates a claim processing decision by the insurer that may negatively affect the worker's benefits. If the worker has questions, he or she may consult an attorney or the Ombudsman for Injured Workers at 1-800-927-1271 (toll-free).**<br>• Report of aggravation of original injury<br>("Aggravation" means the actual worsening of a compensable condition resulting from the original injury.)<br>• Notice of change of attending physician or nurse practitioner.* This means the new provider will be primarily responsible for treatment.<br>Being primarily responsible does NOT include:<br>• *Treatment on an emergency basis*<br>• *Treatment on an "on-call" basis*<br>• *Consulting*<br>• *Specialist care (unless the specialist assumes complete control of care)*<br>• *Exams done at the request of the insurer or the Workers' Compensation Division*<br>*Oregon nurse practitioners, chiropractic physicians, naturopathic physicians, and physician assistants must certify with the Workers' Compensation Division to treat workers' compensation patients and get paid. | • Progress report<br>• Closing report<br>• Palliative care request<br>(Palliative care makes the worker feel better but does not cure a condition. The worker must be in the workforce or in a vocational program to be eligible for palliative care.)<br>The following are not palliative care:<br>• *Prescriptions, prosthetics, braces, and doctors' appointments to monitor them*<br>• *Diagnostic services*<br>• *Life-preserving treatments*<br>• *Curative care to stabilize an acute waxing and waning of symptoms*<br>• *Services to a permanently and totally disabled worker*<br>When requesting palliative care approval from the insurer, include the following in your request:<br>• *Who will provide the care*<br>• *Modalities ordered, including frequency and duration*<br>• *How the need for care is related to the accepted conditions*<br>• *How the care will enable the worker to continue current work or vocational training*. |
| After the worker has completed and signed Form 827, give the worker copies of Form 827 and Form 3283 (included with this packet) immediately. | For these reports, you have the option of filing Form 827, submitting chart notes, or submitting a report that includes data gathered on Form 827. |

**Questions about name/address of insurer:** 503-947-7814 or WorkCompCoverage.wcd.oregon.gov
**Questions about medical issues:** Contact the medical resolution team at 503-947-7606.
**For health care providers:** www.OregonWCdoc.info

**827**

DEPARTMENT OF CONSUMER & BUSINESS SERVICES — *Workers' Compensation Division*

# Worker's and Health Care Provider's Report for Workers' Compensation Claims

OPTIONAL — WCD employer no.: | Policy no.:

**Note to Provider:** **Ask the worker to complete this form ONLY for the four filing reasons in the worker's section; do not have the worker complete or sign form if this is a progress report, closing report, or palliative care request.**

**Dept. Use**: Ins. no. | Occ. | Nature | Part | Event | Source | Assoc. object

## Worker or provider

Worker's legal name, street address, and mailing address:

Phone:

Language preference: | Male/female ☐ ☐ | Social Security no. (see Form 3283):

Claim no. (if known): | Date/time of original injury:

Date of birth: | Occupation: | Last date worked:

Employer at time of original injury — name and street address:

Phone:

Health insurance company name and phone:

Workers' compensation insurer's name, address:

## Worker

***Worker: Check reason for filing this form, answer questions (if any), and sign below.***

☐ **First report of injury or disease** (Do not complete or sign if you do not intend to make a claim.)

Have you injured the same body part before? ☐ Yes ☐ No If yes, when: _____

☐ **Request for acceptance of a new or omitted medical condition on an existing claim**
Checking this box initiates claim processing decisions that may affect your benefits. If you have questions, consult with your attorney or the Ombudsman for Injured Workers at 1-800-927-1271 (toll-free).
Condition: _____

☐ **Notice of change of attending physician or nurse practitioner**
Reason for change: _____

☐ **Report of aggravation of original injury (actual worsening of a compensable condition)**

Check here if you have more than one job. ☐

**Describe accident:**

By signing this form, I authorize health care providers and other custodians of claim records to release relevant medical records. I certify that the above information is true to the best of my knowledge and belief. (See back of form.)

**X** _____ _____
***Worker's signature*** ***Date***

## Provider

***Provider: If worker initiated this report, give worker a copy immediately.***

**If the worker filed this report for:**

- **First report** of injury or illness – **Send this form to the workers' compensation insurer within 72 hours of visit.**
- **New or omitted** medical condition – Attach chart notes that explain how this condition is causally related to the compensable injury. **Send this form to the insurer within five days of visit.**
- **Change of attending physician** or nurse practitioner – By signing this form, you acknowledge that you accept responsibility for the care and treatment of the above-named worker. **Send this form to the insurer within five days** after the change or the date of first treatment. Check the following, if applicable: ☐ **I request insurer to send its records.**
- **Aggravation of original injury** – Sign this form and **send it to insurer within five days of visit.**

**If filing for progress report, closing report, or palliative care request, check the appropriate box below.**

☐ **Progress report** ***OR*** ☐ **Closing report** (See instructions in Bulletin 239.)

☐ **Palliative care request –** Complete remainder of form, except Section b. **Attach a palliative care plan**; state how care relates to the compensable condition, how care will enable worker to continue work or training, adverse effect on worker if care not provided.

To get the name and address of the insurer, call the Workers' Compensation Division's Employer Index 503-947-7814, or visit online:
WorkCompCoverage.wcd.oregon.gov
To order supplies of this form, call 503-947-7627.

**a**

Date/time of first treatment: | Last date treated: | Was worker hospitalized as an inpatient? ☐ Yes ☐ No — If yes, name hospital:

Next appointment date: | Est. length of further treatment: | Current diagnosis per ICD-10-CM codes:

**b**

Has the injury or illness caused permanent impairment? ☐ Yes ☐ No ☐ Impairment expected ☐ Unknown

Medically stationary? ☐ Yes (date): ☐ No (anticipated date): (Attach findings of impairment, if any.)

**Work ability status:**
☐ Regular work (job at injury) authorized start (date): through (date, if known):
☐ Modified work authorized from (date): through (date, if known):
☐ No work authorized from (date):

**c**

**Chart notes**: Attach chart notes to this form. The notes should specifically describe: symptoms; objective findings; type of treatment; lab/x-ray results (if any); impairment findings (if any, and note whether temporary or permanent); physical limitations (if any); palliative care plan (specify rendering provider, modalities, frequency, and duration); if referred to another physician, give the name and address; surgery; and history (if closing report).

Provider's name, degree, address, and phone: *(print, type, or use stamp)*

**X** _____ _____
***Provider's signature*** ***Date***

—Original and one copy to insurer
—Retain copy for your records
—Copies (include Form 3283) to worker immediately if initial claim, new or omitted medical condition claim, aggravation claim, or change of attending physician or nurse practitioner

**827**

# Notice to worker

**Claim acceptance or denial**
In most instances, you will receive written notice from your employer's insurer of the acceptance or denial of your claim within 60 days. If your employer is self-insured, your employer or the company your employer has hired to process its workers' compensation claims will send the notice to you. If the insurer or self-insured employer denies your claim, it will explain the reason for the denial and your rights.

**Medical care**
The health care provider must tell you if there are any limits to the medical services he or she may provide to you under the Oregon workers' compensation system.

If your claim is accepted, the insurer or self-insured employer will pay medical bills due to medical conditions the insurer accepts in writing, including reimbursement for prescription medications, transportation, meals, lodging, and other expenses up to a maximum established rate. You must make a written request for reimbursement and attach copies of receipts. Medical bills are not paid before claim acceptance. Bills are not paid if your claim is denied, with some exceptions. Contact the insurer if you have questions about who will pay your medical bills.

**Payments for time lost from work**
**In order for you to receive payments for time lost from work, your health care provider must notify the insurer or self-insured employer of your inability to work**. After the original injury, you will not be paid for the first three calendar days you are unable to work unless you are totally disabled for at least 14 consecutive calendar days or you are admitted to a hospital as an inpatient within 14 days of the first onset of total disability.

You will receive a compensation check every two weeks during your recovery period as long as your health care provider verifies your inability to work. These checks will continue until you return to work or it is determined further treatment is not expected to improve your condition. Your time-loss benefits will be two-thirds of your gross weekly wage at the time of injury up to a maximum set by Oregon law.

**Authorization to release medical records**
By signing this form, you authorize health care providers and other custodians of claim records to release relevant records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization.

**Caution against making false statements**
Any person who knowingly makes any false statement or representation for the purpose of obtaining any benefit or payment commits a Class A misdemeanor under ORS 656.990(1).

**Palliative care**
Palliative care is care that makes you feel better, but does not cure you of an unwanted condition. You must be in the workforce, or in a vocational program, to be allowed to have palliative care.

The following are **not** palliative care:

- Prescriptions, prosthetics, braces, and doctors' appointments to monitor them
- Diagnostic services
- Life-preserving treatments
- Curative care to stabilize an acute waxing and waning of symptoms
- Services to a permanently and totally disabled worker

If you have questions about your claim that are not resolved by your employer or insurer, you may contact:

(Si Ud. tiene alguna pregunta acerca de su reclamación que no haya sido resuelta por su empleador o compañía aseguradora, puede ponerse en contacto con):

**Workers Compensation Division**
**(División de Compensación para Trabajadores)**
P.O. Box 14480, Salem, OR 97309-0405
Salem: 503-947-7585
Toll-free: 800-452-0288

**Ombudsman for Injured Workers**
**(Ombudsman para Trabajadores Lastimados)**
350 Winter Street NE, Salem, OR 97301-3878
Salem: 503-378-3351
Toll-free: 800-927-1271

OREGON DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Workers' Compensation Division

# A Guide for Workers Recently Hurt on the Job

## How do I file a claim?

- Notify your employer and a health care provider **of your choice** about your job-related injury or illness as soon as possible. Your employer cannot choose your health care provider for you.
- Ask your employer the name of its workers' compensation insurer.
- Complete **Form 801, "Report of Job Injury or Illness,"** available from your employer and **Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims,"** available from your health care provider.

## How do I get medical treatment?

- You may receive medical treatment from the health care provider **of your choice**, including:
  - Authorized nurse practitioners
  - Chiropractic physicians
  - Medical doctors
  - Naturopathic physicians
  - Oral surgeons
  - Osteopathic doctors
  - Physician assistants
  - Podiatric physicians
  - Other health care providers
- The insurance company may enroll you in a managed care organization at any time. If it does, you will receive more information about your medical treatment options.

## Are there limitations to my medical treatment?

- **Health care providers may be *limited* in how long they may treat you and whether they may authorize payments for time off work.** Check with your health care provider about any limitations that may apply.
- **If your claim is denied, you may have to pay for your medical treatment.**

## If I can't work, will I receive payments for lost wages?

- You may be unable to work due to your job-related injury or illness. In order for you to receive payments for time off work, your health care provider must send written authorization to the insurer.
- Generally, you will not be paid for the first three calendar days for time off work.
- You may be paid for lost wages for the first three calendar days if you are off work for 14 consecutive days or hospitalized overnight.
- If your claim is denied within the first 14 days, you will not be paid for any lost wages.
- Keep your employer informed about what is going on and cooperate with efforts to return you to a modified- or light-duty job.

## What if I have questions about my claim?

- The insurance company or your employer should be able to answer your questions.
- If you have questions, concerns, or complaints, you may also call any of the numbers below:

**Ombudsman for Injured Workers:**
**An advocate for injured workers**
Toll-free: 800-927-1271
Email: oiw.questions@oregon.gov

**Workers' Compensation Resolution Section**
Toll-free: 800-452-0288
Email: workcomp.questions@oregon.gov

**Do I have to provide my Social Security number on Forms 801 and 827? What will it be used for?** You do not need to have an SSN to get workers' compensation benefits. If you have an SSN, and don't provide it, the Workers' Compensation Division (WCD) of the Department of Consumer and Business Services will get it from your employer, the workers' compensation insurer, or other sources. WCD may use your SSN for: quality assessment, correct identification and processing of claims, compliance, research, injured worker program administration, matching data with other state agencies to measure WCD program effectiveness, injury prevention activities, and to provide to federal agencies in the Medicare program for their use as required by federal law. The following laws authorize WCD to get your SSN: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).

440-3283 (07/10/DCBS/WCD/WEB)

DEPARTMENT OF CONSUMER & BUSINESS SERVICES *Workers' Compensation Division*

**Reporte del Trabajador y del Proveedor Médico para Reclamaciones de Compensación para Trabajadores**
**(Worker's and Health Care Provider's Report for Workers' Compensation Claims)**
***Vea en el reverso de esta página las instrucciones en español***
*(See back of this page for instructions in Spanish)*

# Health care provider instructions

The worker **should** complete the worker section of this form for the following:

- First report of injury or disease
- Request for acceptance of a new or omitted medical condition
  ("Omitted" refers to a condition the worker thinks should have been included among the conditions accepted by the insurer.)
- Report of aggravation of original injury
  ("Aggravation" means the actual worsening of a compensable condition resulting from the original injury.)
- Notice of change of attending physician or nurse practitioner.* This means the new provider will be primarily responsible for treatment.
  Being primarily responsible does NOT include:
  - *Treatment on an emergency basis*
  - *Treatment on an "on-call" basis*
  - *Consulting*
  - *Specialist care (unless the specialist assumes complete control of care)*
  - *Exams done at the request of the insurer or the Workers' Compensation Division*

*Oregon nurse practitioners, chiropractic physicians, naturopathic physicians, and physician assistants must certify with the Workers' Compensation Division to treat workers' compensation patients and get paid.

After the worker has completed and signed Form 827s, give the worker copies of Form 827s and Form 3283s (included with this packet) immediately.

The worker **should NOT** complete the worker section of this form if you choose to use it for the following:

- Progress report
- Closing report
- Palliative care request
  (Palliative care makes the worker feel better but does not cure a condition. The worker must be in the workforce or in a vocational program to be eligible for palliative care.)
  The following are not palliative care:
  - *Prescriptions, prosthetics, braces, and doctors' appointments to monitor them*
  - *Diagnostic services*
  - *Life-preserving treatments*
  - *Curative care to stabilize an acute waxing and waning of symptoms*
  - *Services to a permanently and totally disabled worker*

  When requesting palliative care approval from the insurer, include the following in your request:
  - *Who will provide the care*
  - *Modalities ordered, including frequency and duration*
  - *How the need for care is related to the accepted conditions*
  - *How the care will enable the worker to continue current work or vocational training*

For these reports, you have the option of filing Form 827s, submitting chart notes, or submitting a report that includes data gathered on Form 827s.

***Questions about name/address of insurer:*** *503-947-7814 or WorkCompCoverage.wcd.oregon.gov*
***Questions about medical issues:*** *Contact the medical resolution team at 503-947-7606*
***For health care providers:*** *www.oregonwcdoc.info*

**827s**

DEPARTMENT OF CONSUMER & BUSINESS SERVICES *Workers' Compensation Division*

# Reporte del Trabajador y del Proveedor Médico para Reclamaciones de Compensación para Trabajadores

**(Worker's and Health Care Provider's Report for Workers' Compensation Claims)**

## Instrucciones para el proveedor médico

El trabajador **debe** completar esta forma en las siguientes circunstancias:

- Primer reporte de lesión o enfermedad
- Solicitud para aceptación de una condición médica nueva u omitida
  ("Omitida" se refiere a una condición que el trabajador piensa que debería haber sido incluida entre las condiciones aceptadas por la aseguradora.)
- Reporte de agravación de la lesión original
  ("Agravación" significa el empeoramiento actual de una condición médica aceptada que resulta de la lesión original.)
- Notificación de cambio de proveedor médico o enfermera(o) practicante * Esto significa que el nuevo proveedor médico será primariamente responsable por el tratamiento.
  Ser primariamente responsable **NO** incluye:
  - *Tratamiento en caso de emergencia*
  - *Tratamiento por un médico de turno (on-call)*
  - *Consulta médica*
  - *Tratamiento por un médico especialista (a menos de que el especialista asuma control completo del cuidado médico)*
  - *Exámenes médicos a pedido de la aseguradora o la División de Compensación para Trabajadores*

*Enfermeros practicantes de Oregon, doctores quiroprácticos, doctores naturópatas, y asistentes médicos deben tener certificación de la División de Compensación para Trabajadores para tratar pacientes con seguro de compensación para trabajadores y recibir pago.

Después de que el trabajador llena y firma el Formulario 827s, inmediatamente entregar al trabajador copias del Formulario 827s y el Formulario 3283s (incluido en este paquete).

El trabajador **NO** debe completar la sección que le corresponde en este formulario para lo siguiente:

- Reporte de progreso
- Clausura del reporte
- Solicitud de cuidado paliativo
  (Cuidado Paliativo es un servicio médico que puede ayudar al trabajador a sentirse mejor, pero que no va a curar una condición médica. Para calificar para cuidado paliativo el trabajador debe estar trabajando, o estar en un programa vocacional.)
  Los siguientes no son servicios de cuidado paliativo:
  - *Prescripciones médicas, dispositivos prostéticos, soportes (braces), y citas médicas para control y monitoreo*
  - *Servicios de diagnóstico*
  - *Tratamientos para preservar la vida*
  - *Cuidados curativos para estabilizar un severo aumento y disminución de síntomas*
  - *Servicios provistos a un trabajador incapacitado total y permanentemente*

  Para solicitar aprobación de la aseguradora para cuidado paliativo, incluya lo siguiente en su solicitud:
  - *Quién proveerá el cuidado paliativo*
  - *Modalidades ordenadas, incluyendo la frecuencia y duración*
  - *Cómo se relaciona la necesidad del cuidado con la condición aceptada*
  - *Cómo el cuidado permitirá que el trabajador continúe con el trabajo actual o entrenamiento vocacional*

Para estos reportes, usted tiene la opción de llenar la forma 827s, presentar notas, o reportes que incluyen información obtenida del formulario 827s.

***Para preguntas acerca del nombre o dirección de la aseguradora:*** *503-947-7814 or WorkCompCoverage.wcd.oregon.gov*
***Para preguntas acerca de asuntos médicos:*** *Lláme a la medical resolution team at 503-947-7606*
***Para proveedores del cuidado de la salud visite:*** *www.oregonwcdoc.info*

**827s**

DEPARTMENT OF CONSUMER & BUSINESS SERVICES — *Workers' Compensation Division*

# Reporte del Trabajador y del Proveedor Médico para Reclamaciones de Compensación para Trabajadores
## (Worker's and Health Care Provider's Report for Workers' Compensation Claims)

OPTIONAL — WCD employer no.: ____ Policy no.: ____

**Note to Provider:** **(Nota para el Proveedor Médico)** **Ask the worker to complete this form ONLY for the four filing reasons in the worker's section; do not have the worker complete or sign form if this is a progress report, closing report, or palliative care request.**

**Dept. Use** — Ins. no. / Occ. / Nature / Part / Event / Source / Assoc. object

## Trabajador o Proveedor Médico (Worker or provider)

Nombre legal del trabajador, dirección, y dirección postal (Worker's legal name, street address, and mailing address):

Teléfono (Phone):

Idioma de preferencia (Language preference):

Masculino/ Femenino (Male/female) ☐ ☐

Número de Seguro Social (vea Forma 3283s) (Social Security no. (see Form 3283s)):

Número de reclamación (si lo sabe) (Claim no. (if known)):

Fecha y hora de la lesión o enfermedad inicial (Date/time of original injury) (mes, día, año):

Fecha de nacimiento: (Date of birth) (mes, día, año)

Ocupación (Occupation):

Ultimo día de trabajo: (Last date worked) (mes, día, año)

Nombre y dirección del empleador al momento de la lesión original (Employer at time of original injury — name and street address):

Teléfono (Phone):

Nombre y teléfono de la compañía de seguro de salud (Health insurance company name and phone):

Nombre y dirección de la compañía aseguradora de compensación para trabajadores (Workers' compensation insurer's name, address):

## Trabajador (Worker)

***Trabajador: Marque la casilla apropriada, conteste las preguntas (si hay algunas), y firme abajo.***

☐ **Primer reporte de lesión o enfermedad ocupacional** (No firme si usted no tiene la intención de registrar una reclamación.) (**First report of injury or disease** (Do not complete or sign if you do not intend to make a claim.))

Se ha lesionado la misma parte del cuerpo anteriormente? (Have you injured the same body part before?) ☐Si ☐No Si contesto sí, cuando: (If yes, when:) ____

☐ **Solicitud para aceptación de una condición médica nueva u omitida en una reclamación existente** **(Request for acceptance of a new or omitted medical condition on an existing claim)**

Condición (Condition): ____

☐ **Cambio de médico primario o enfermera(o) practicante** (Notice of change of attending physician or nurse practitioner)

Razón para cambio (Reason for change): ____

☐ **Reporte de agravamiento de la lesión original (empeoramiento actual de la condición compensable)** (Report of aggravation of original injury (actual worsening of a compensable condition))

Marque aquí si tiene más de un empleador. ☐ (Check here if you have more than one job.)

**Describa el accidente** (Describe accident):

Al firmar este formulario, yo autorizo a los proveedores médicos y otros custodios de los expedientes de mi reclamación para proveer los expedientes médicos relevantes. Yo certifico que la información arriba provista es verdadera en el mejor de mi conocimiento y creencia. (Vea el reverso del formulario.)

(By signing this form, I authorize health care providers and other custodians of claim records to release relevant medical records. I certify that the above information is true to the best of my knowledge and belief. (See back of form.))

X ____ ***Firma del trabajador** (Worker's signature)* ____ ***Fecha** (Date)*

## Provider

***Provider: If worker initiated this report, give worker a copy immediately.***

**If the worker filed this report for:**

- **First report** of injury or illness – **Send this form to the workers' compensation insurer within 72 hours of visit.**
- **New or omitted** medical condition – Attach chart notes, including diagnostic codes. **Send this form to the insurer within five days of visit.**
- **Change of attending physician** or nurse practitioner – By signing this form, you acknowledge that you accept responsibility for the care and treatment of the above-named worker**. Send this form to the insurer within five days** after the change or the date of first treatment. Check the following, if applicable: ☐ **I request insurer to send its records.**
- **Aggravation of original injury** – Sign this form and **send it to insurer within five days of visit**.

**If filing for progress report, closing report, or palliative care request, check the appropriate box below.**

☐ **Progress report** ***OR*** ☐ **Closing report** (See instructions in Bulletin 239.)

☐ **Palliative care request** – Complete remainder of form, except Section b. **Attach a palliative care plan**; state how care relates to the compensable condition, how care will enable worker to continue work or training, adverse effect on worker if care not provided.

To get the name and address of the insurer, call the Workers' Compensation Division's Employer Index 503-947-7814, or visit online: WorkCompCoverage.wcd.oregon.gov

To order supplies of this form, call 503-947-7627.

**a**

Date/time of first treatment: ____ Last date treated: ____ Was worker hospitalized as an inpatient? ☐Yes ☐No If yes, name hospital: ____

Next appointment date: ____ Est. length of further treatment: ____ Current diagnosis per ICD-10-CM codes: ____

**b**

Has the injury or illness caused permanent impairment? ☐ Yes ☐ No ☐ Impairment expected ☐ Unknown

Medically stationary? ☐ Yes (date): ____ ☐ No (anticipated date): ____ (Attach findings of impairment, if any.)

**Work ability status:**

☐ Regular work (job at injury) authorized start (date): ____

☐ Modified work authorized from (date): ____ through (date, if known): ____

☐ No work authorized from (date): ____ through (date, if known): ____

**c**

**Chart notes**: Attach chart notes to this form. The notes should specifically describe: symptoms; objective findings; type of treatment; lab/x-ray results (if any); impairment findings (if any, and note whether temporary or permanent); physical limitations (if any); palliative care plan (specify rendering provider, modalities, frequency, and duration); if referred to another physician, give the name and address; surgery; and history (if closing report).

Provider's name, degree, address, and phone: *(print, type, or use stamp)*

X ____ ***Provider's signature*** ____ ***Date***

— Original and one copy to insurer
— Retain copy for your records
— Copies (include Form 3283s) to worker immediately if initial claim, new or omitted medical condition claim, aggravation claim, or change of attending physician or nurse practitioner

**827s**

# Notificación al trabajador (Notice to worker)

**Aceptación o Rechazo de Reclamación**
En la mayoría de los casos usted recibirá notificación escrita de parte de la compañía aseguradora de su empleador aceptando o rechazando su reclamación antes de 60 días. Si su empleador está asegurado por sí mismo, el aviso le será enviado por su empleador o la compañía que el empleador haya contratado para procesar sus reclamaciones de compensación para trabajadores. Si su reclamación es rechazada, se le explicará las razones del rechazo y sus derechos.

**Atención médica**
El proveedor médico debe avisarle si hay algún límite con los servicios médicos que él o ella pueden proveer bajo el sistema de compensación para trabajadores de Oregon.

Si su reclamación es aceptada, la aseguradora o el empleador asegurado por sí mismo pagarán todos los costos médicos relacionados con la lesión, incluyendo reembolsos por prescripciones médicas, transportación, comidas, alojamiento, y otros gastos relacionados con el tratamiento de su condición hasta por el máximo establecido. Su petición para reembolso deberá hacerse por escrito y deberá incluir copias de los recibos. Los pagos de servicios médicos no se reembolsarán antes de la aceptación de su reclamación. Si su reclamación es rechazada no se pagarán las cuentas, con algunas excepciones. Póngase en contacto con su aseguradora si tiene preguntas acerca de quien pagará sus gastos médicos.

**Pagos por tiempo perdido de trabajo**
**Para que usted reciba pagos por el tiempo perdido de trabajo, su proveedor médico deberá notificar a la aseguradora o al empleador asegurado por sí mismo de su incapacidad para trabajar.** Usted no recibirá pago por los tres primeros días calendarios que no pueda trabajar, a menos que usted esté totalmente incapacitado por 14 días calendarios consecutivos, o usted sea internado en un hospital dentro de los 14 días a partir del principio de la incapacidad total.

Usted continuará recibiendo cheques cada dos semanas durante el período de su recuperación siempre y cuando su proveedor médico verifique su incapacidad para trabajar. Estos cheques continuarán hasta que usted regrese al trabajo, o se determine que la continuación del tratamiento no mejorará su condición. Sus beneficios por tiempo perdido de trabajo serán dos tercios del pago bruto de su salario semanal al momento del accidente, hasta el máximo establecido bajo la ley de Oregon.

**Autorización para compartir información sobre expedientes médicos**
Al firmar este formulario, usted autoriza a los proveedores de servicios médicos y otros custodios de los expedientes de su reclamación para que compartan información pertinente con la aseguradora de compensación para trabajadores, el empleador auto-asegurado, el administrador del reclamo, y con el Departamento de Servicios para Consumidores y Negocios. Los expedientes médicos que contienen información relevante a la reclamación incluyen su historial de tratamientos anteriores por la misma condición o lesión de la misma parte del cuerpo. Una autorización de HIPPA no es requerida (45CFR 164.512(I)). Para compartir récords sobre el HIV/AIDS (SIDA), ciertos tratamientos de drogadicción o alcoholismo y otros records protegidos por la ley estatal o federal se requiere una autorización separada.

**Advertencia en contra de hacer declaraciones falsas**
Cualquier persona que intencionalmente hace declaraciones o representaciones falsas con el propósito de obtener cualquier beneficio o pago, está cometiendo un delito menor Clase A bajo el Estatuto Revisado de Oregon ORS 656.990(1).

**Cuidado Paliativo**
Cuidado Paliativo es un servicio médico que puede ayudarle a sentirse mejor, pero que no lo va a curar de su condición médica. Para calificar para cuidado paliativo usted debe estar trabajando, o en un programa vocacional.

Los siguientes **no** son considerados como cuidado paliativo:

- Prescripciones médicas, dispositivos prostéticos, soportes (braces), y citas médicas para control y monitoreo
- Servicios de diagnóstico
- Tratamientos para preservar la vida;
- Cuidados curativos para estabilizar un severo aumento y disminución de síntomas
- Servicios provistos a un trabajador incapacitado total y permanentemente

Si tiene alguna pregunta acerca de su reclamación que su empleador o compañía aseguradora no hayan podido resolver, póngase en contacto con:

**Workers Compensation Division**
**(División de Compensación para Trabajadores)**
P.O. Box 14480, Salem, OR 97309-0405
Salem: 503-947-7585
Toll-free: 800-452-0288

**Ombudsman for Injured Workers**
**(Ombudsman para Trabajadores Lastimados)**
350 Winter Street NE, Salem, OR 97301-3878
Salem: 503-378-3351
Toll-free: 800-927-1271

OREGON DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Workers' Compensation Division

# Una Guía para Trabajadores Lesionados Recientemente en el Trabajo

## ¿Cómo presento un reclamación?

- Lo más pronto posible notifique de su lesión o enfermedad en el trabajo a su empleador y a un proveedor médico **de su elección**. Su empleador no puede elegir el proveedor médico para usted.
- Pregunte a su empleador el nombre de su compañía de compensación para trabajadores.
- Complete la **Forma 801, "Reporte de Lesión o Enfermedad en el Trabajo"** la forma puede ser obtenida de su empleador. También llene la **Forma 827, "Reporte del Trabajador y del Proveedor Médico para Reclamaciones de Compensación para Trabajadores"** esta forma puede ser obtenida de su proveedor médico**.**

## ¿Cómo obtengo tratamiento médico?

- Usted puede recibir tratamiento médico de un proveedor médico **de su elección,** incluyendo:
  - Enfermeras(os) practicantes autorizadas(os)
  - Médicos Quiroprácticos
  - Médicos
  - Médicos Naturopáticos
  - Cirujanos Orales
  - Médicos Osteopáticos
  - Asistentes de doctor
  - Médicos Podólogos
  - Otros proveedores médicos
- La compañía de seguros puede inscribirlo en una organización de manejo del cuidado médico a cualquier momento. Si la compañía lo hace, usted recibirá más información acerca de las opciones para tratamiento médico.

## ¿Existen limitaciones en mi tratamiento médico?

- **Los proveedores de cuidado médico pueden tener *limitaciones* en cuanto a la duración de su tratamiento y en cuanto a la autorización de pago por tiempo fuera del trabajo.** Pregunte a su proveedor médico cuales son las limitaciones que pueden aplicarse.
- **Si su reclamación es negada, es posible que usted tenga que pagar por su tratamiento médico.**

## Si no puedo trabajar, ¿recibiré pagos por salario perdido?

- Es posible que no pueda trabajar debido a su lesión o enfermedad relacionada con el trabajo. Para que usted pueda recibir pago por tiempo fuera del trabajo, su proveedor médico debe enviar una autorización escrita a la aseguradora.
- Generalmente, usted no recibirá pagos por tiempo perdido por los tres primeros días calendarios.
- Es posible que reciba pago por los tres primeros días calendarios, si usted pierde de trabajar por 14 días consecutivos, o es hospitalizado durante un día incluyendo la noche.
- Si su reclamación es negada dentro de los primeros 14 días, no se le pagará por ningún salario perdido.
- Mantenga informado a su empleador acerca del estado de la reclamación y coopere con los esfuerzos para que regrese a trabajar en un trabajo modificado o liviano.

## ¿A quién puedo llamar si tengo preguntas acerca de mi reclamación?

- La compañía de seguros o su empleador pueden responder a sus preguntas.
- También puede llamar a los siguientes números:

**Ombudsman para Trabajadores Lesionados:**
Número gratuito: 1-800-927-1271
Email: oiw.questions@oregon.gov

**Sección de Resolución de Compensación para Trabajadores:**
Número gratuito: 1-800-452-0288
Email: workcomp.questions@oregon.gov

¿**Debo proveer mi número de seguro social en las formas 801 y 827?** ¿**Para qué será usado?** Usted no necesita tener un número de seguro social para recibir beneficios de compensación para trabajadores. Si usted tiene número de seguro social y no lo provee, la División de Compensación para Trabajadores (WCD) del Departamento de Servicios para Consumidores y Negocios lo obtendrá de su empleador, de su aseguradora de compensación para trabajadores, o de otros recursos. WCD puede usar su número de seguro social para intercambio de datos con el Departamento de Empleo, corregir identificación y procesamiento de reclamaciones, cumplimiento, investigación, administración de un programa para trabajadores lesionados, comparación de datos con otras agencias del estado para medir la efectividad de programas de WCD, actividades para prevención de lesiones, y para proveerlo a agencias federales en el programa de Medicare para su uso como está requerido por la ley federal. Las siguientes leyes autorizan a WCD a obtener su número de seguro social: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).

440-3283s (7/10 tr 7/10/DCBS/WCD/WEB)

*Insert self-insured employer and insurer name, address, phone number, and service company, if any.*

# Report of Job Injury or Illness

Workers' compensation claim

## Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give it to your employer. **If you do not intend to file a workers' compensation claim with the insurance company, do not sign the signature line.** Your employer will give you a copy.

| | | | | |
|---|---|---|---|---|
| Date of injury or illness: | Date you left work: | Time you began work on day of injury: ☐ a.m. ☐ p.m. | Regularly scheduled days off: ☐☐☐☐☐☐☐ M T W T F S S | **DEPT USE:** Emp |
| Time of injury or illness: ☐ a.m. ☐ p.m. | Time you left work: ☐ a.m. ☐ p.m. | Check here if you have more than one job: ☐ | | Ins |
| What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot) ☐Left ☐Right | | | | Occ |
| | | | | Nat |
| What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials) | | | | Part |
| | | | | Ev |
| | | | | Src |
| | | | | 2src |

***Information ABOVE this line; date of death, if death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.***

| | | | |
|---|---|---|---|
| Your legal name: | Language preference: | Birthdate: | Gender: M ☐ F ☐ |
| Your mailing address: | | Home phone: | |
| Social Security no. (see Form 3283): | Occupation: | Work phone: | |
| Names of witnesses: | | | |
| Name and phone number of health insurance company: | | Name and address of health care provider who treated you for the injury or illness you are now reporting: | |
| Were you hospitalized overnight? ☐ Yes ☐ No | | | |
| Were you treated in the emergency room? ☐ Yes ☐ No | | | |

**By my signature,** I am making a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization.

| | | |
|---|---|---|
| Worker signature: | Completed by (please print): | Date: |

## Employer

Complete the rest of this form and give a copy of the form to the worker. Notify your workers' compensation insurance company within five days of knowledge of the claim. Even if the worker does not wish to file a claim, maintain a copy of this form.

| | | | | |
|---|---|---|---|---|
| Employer legal business name: | | Phone: | | FEIN: |
| If worker leasing company, list client business name: | | | | Client FEIN: |
| Address of principal place of business (not P.O. Box): | | | | Insurance policy no.: |
| Street address from which worker is/was supervised: ZIP: | | | | Nature of business in which worker is/was supervised: |
| Address where event occurred: | | | | |
| Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No | | | | |
| Were other workers injured? ☐ Yes ☐ No | | | OSHA 300 log case no: | |
| Date employer knew of claim: | Date worker returned to work: | Worker's weekly wage: $ | Date worker hired: | If fatal, date of death: |
| Employer signature: | | Name and title (please print): | | Date: |

**OSHA requirements:** Employers must report work-related fatalities and catastrophes to Oregon OSHA either in person or by telephone within eight hours. In addition, employers must report any in-patient hospitalization, loss of an eye, and any amputation or avulsion that results in bone or cartilage loss to Oregon OSHA within 24 hours. See OAR 437-001-0704. Call 800-922-2689 (toll-free), 503-378-3272, or Oregon Emergency Response, 800-452-0311 (toll-free), on nights and weekends.

*Insert self-insured employer and insurer name, address, phone number, and service company, if any.*

# Reporte de Lesión o Enfermedad en el Trabajo

**(Report of Job Injury or Illness)**

Reclamación de compensación para trabajadores

(Workers' compensation claim)

## Trabajador (Worker)

Para hacer una reclamación por una lesión o enfermedad ocupacional, llene la parte de esta forma que corresponde al trabajador y entregela a su empleador. **Si usted no quiere hacer una reclamación de compensación para trabajadores con la aseguradora, no firme en la línea dejada para su firma.** Su empleador le dará una copia. (To make a claim for a work-related injury or illness, fill out the worker portion of this form and give to your employer. **If you do not intend to file a workers' compensation claim with the insurance company, do not sign the signature line.** Your employer will give you a copy. )

| | | | | |
|---|---|---|---|---|
| Fecha de la lesión o enfermedad (Date of injury or illness): | Fecha que dejó el trabajo (Date you left work): | Hora que empezó a trabajar el día de la lesión (Time you began work on day of injury): ☐ a.m. ☐ p.m. | Días que regularmente no trabaja (Regularly scheduled days off) ☐☐☐☐☐☐☐ M T W T F S S | **DEPT USE:** Emp |
| Hora en la que ocurrió la lesión o enfermedad (Time of injury or illness): ☐ a.m. ☐ p.m. | Hora que dejó el trabajo (Time you left work): ☐ a.m. ☐ p.m. | Marque este casillero si usted tiene más de un trabajo. (Check here if you have more than one job): ☐ | | Ins |
| | | | | Occ |
| | | | | Nat |
| ¿Cuál es su lesión o enfermedad? ¿En qué parte del cuerpo? ¿En qué lado? (Ejemplo: torcedura del pie derecho) What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) ☐ Izquierdo (Left) ☐ Derecho (Right) | | | | Part |
| | | | | Ev |
| ¿Cuál fue la causa? ¿Qué estaba haciendo? Incluya vehículo, maquinaria o herramienta usada. (Ejemplo: caí diez pies mientras subía una escalera de extención cargando una caja de materiales que pesaba 40 libras) What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carrying a 40-lb. box of roofing materials) | | | | Src |
| | | | | 2src |

***Information ABOVE this line; date of death, if death occurred; and OR-OSHA case log number must be released to an authorized worker representative upon request.***

| | | | |
|---|---|---|---|
| Su nombre legal (Your legal name): | Idioma de preferencia (Language preference): | Fecha de nacimiento (Birthdate): | Sexo (Gender): M ☐ F ☐ |
| Su dirección postal (Your mailing address): | | Teléfono del domicilio (Home phone): | |
| Número de Seguro Social SSN (Vea la Forma 3283) (See Form 3283): | Ocupación (Occupation): | Teléfono del trabajo (Work phone): | |
| Nombres de testigos (Names of witnesses): | | | |
| Nombre y número de teléfono de la compañía aseguradora de salud (Name and phone number of health insurance company): | | Nombre y dirección del proveedor médico que le trató de la lesión o enfermedad que usted está ahora reportando (Name and address of health care provider who treated you for the injury or illness you are now reporting): | |
| ¿Estuvo hospitalizado como paciente durante la noche? (Were you hospitalized overnight as an inpatient?) ☐ Si ☐ No | | | |
| ¿Recibió tratamiento en la sala de emergencia? (Were you treated in the emergency room?) ☐ Si ☐ No | | | |

**Con mi firma,** estoy presentando una reclamación para beneficios de compensación para trabajadores. La información arriba provista es verdadera en el mejor de mi conocimiento y creencia. Yo autorizo a proveedores médicos y a otros custodios de los récords de mi reclamación para emitir los expedientes médicos pertinentes a la aseguradora de compensación para trabajadores, empleador asegurado por sí mismo, administrador de reclamaciones, y al Departamento para Consumidores y Negocios de Oregon. **Aviso:** Los expedientes médicos pertinentes incluyen registros de tratamiento anterior por las mismas condiciones o lesiones a la misma parte del cuerpo. Una autorización de HIPAA no es requerida (45 CFR 164.512(I)). Para emitir récords sobre el HIV/AIDS (SIDA), ciertos récords de tratamiento de drogadicción o alcoholismo, y otros récords protegidos por la ley estatal o federal se requiere una autorización separada.

(**By my signature, I** am making a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization.)

| | | |
|---|---|---|
| Firma del trabajador (Worker signature): | Completada por (Completed by) Por favor escriba (please print): | Fecha (Date): |

## Empleador (Employer)

Complete the rest of this form and give a copy of the form to the worker. Notify your workers' compensation insurance company within five days of knowledge of the claim. Even if the worker does not wish to file a claim, maintain a copy of this form.

| | | |
|---|---|---|
| Employer legal business name: | Phone: | FEIN: |
| If worker leasing company, list client business name: | | Client FEIN: |
| Address of principal place of business (not P.O. Box): | | Insurance policy no.: |
| Street address from which worker is/was supervised: ZIP: | | Nature of business in which worker is/was supervised: |
| Address where event occurred: | | |

Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No

| | | | | |
|---|---|---|---|---|
| Were other workers injured? ☐ Yes ☐ No | | | OSHA 300 log case #: | |
| Date employer knew of claim: | Date worker returned to work: | Worker's weekly wage: $ | Date worker hired: | If fatal, date of death: |
| Employer signature: | Name and title (please print): | | | Date: |

**OSHA requirements: Employers must report work-related fatalities and catastrophes to Oregon OSHA either in person or by telephone within eight hours. In addition, employers must report any in-patient hospitalization, loss of an eye, and any amputation or avulsion that results in bone or cartilage loss to Oregon OSHA within 24 hours. See OAR 437-001-0704. Call 800-922-2689 (toll-free), 503-378-3272, or Oregon Emergency Response, 800-452-0311 (toll-free), on nights and weekends.**

**801S**

440-801S (1/16 tr 1/16/DCBS/WCD/WEB)