FORT BELKNAP INSURANCE COMPANY
UNEMPLOYMENT, WORKER'S COMPENSATION, AND BURIAL ASSISTANCE
281 Chippewa Avenue/P.O. Box 146 Harlem, MT 59526
Phone: (406) 353-4181/Fax: (406) 353-4934
E-mail: fbinsur4@itstriangle.com

WORKER'S COMPENSATION

CLAIMANTS NEED TO COMPLETE THE FOLLOWING:

1. All medical documents related to injury
2. Statement from injured Employee
3. Supervisor's Report
4. Witness Statement

Please return all completed documents into Fort Belknap Insurance Company as soon as possible.

Noelle Boe, Claims Assistant **406-353-4181 Ext. 1**
Jarrett Azure, Claim Manager **406-353-4181 Ext. 3**

OSHA Log Case #

First Report

of Injury or Occupational Disease
Montana Department of Labor and Industry
PO Box 8011, Helena, MT 59604-8011

Adjuster Date Stamp

Worker

Last Name	First Name	M.I.	Date of Birth	Social Security Number

Mailing Address	City	State	Postal Code

Phone Number	Education	Gender	Marital Status	Number of Dependents
	☐ Less Than High School ☐ GED or High School Diploma ☐ Beyond High School	☐ Male ☐ Female ☐ Unknown	☐ Married ☐ Separated ☐ Widowed, Divorced, Single, Unmarried ☐ Unknown	

Wages

Date Hired	Gross earnings for four pay periods preceding the injury Date/Amount / Date/Amount / Date/Amount / Date/Amount /

Employment Status	Number of Days worked per week	Wage	Wage Period
☐ Full-Time ☐ Part-Time ☐ Piece Worker ☐ Seasonal ☐ Volunteer ☐ Other			☐ Hour ☐ Week ☐ Month ☐ Day ☐ Bi-Weekly

In addition to gross earnings cited above worker received	Estimated value if any	Time Employee began work
☐ Room & Board ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other:		

Worked next scheduled shift	Off work more than 4 work days	Date Last Worked	Date of Return to Work	Full wages paid for date of injury	Salary Continued
☐ Yes ☐ No	☐ Yes ☐ No ☐ Not Sure			☐ Yes ☐ No	☐ Yes ☐ No

Accident Description

Job Title	Description of Accident

Cause of Injury	Cause Code	Part of Body	Part Code	Nature of Injury	Nature Code	Date of Injury	Time of Injury

Date Disability Began	Date of Death	Names of Witnesses 1) 2) 3)

Accident on Employer's Premises	Accident Address or Location City State Postal code
☐ Yes ☐ No	

Date Employer Notified	Accident Reported to	Safety Equipment Provided	Safety Equipment Used
		☐ Yes ☐ No	☐ Yes ☐ No

Medical

Attending Physician's Name	Address	State	Postal Code	Phone Number

Hospital Name	Address	State	Postal Code	Phone Number

Type of initial medical treatment received ☐ No Treatment ☐ Emergency Room/Urgent Care ☐ Treatment on-site by Employer or Medical Staff ☐ Clinic/Dr. Office ☐ Hospital > 24 hours

Signature

"This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease, or death of the above named worker. I understand that signing this claim for compensation authorizes the release to the workers' compensation insurer (and its agents) and to the Montana Uninsured Employers' Fund of: Social Security records; rehabilitation records; and all health care information (medical records, pursuant to HIPAA, Public Law 104-191, 42 USC section 1301, et. seq., and section 39-71-604, MCA), that are directly relevant to the claimed injury, disease, or death. I also understand that if I obtain or exert unauthorized control over workers' compensation benefits to which I am not entitled, I may be prosecuted for theft."

Signature of Injured Worker or Beneficiary _____ Date: _____

Employer

Employer Name	Doing Business as	Federal Employer Identification Number (Tax I.D)

Mailing Address	City	State	Postal Code	Phone Number

Location of operation, if different from mailing address	Nature of Business SIC/NAICS Code	Self-Insured ☐ Yes ☐ No

Employer is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company	Injured worker is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ A member of the employer's (sole proprietor) family living in the employer's household.

Do you have any reason to question this accident? ☐ Yes ☐ No If yes, please explain fully. Use separate sheet if you need additional space	Was worker injured while in your employ ☐ Yes ☐ No

Prepared By	Official Title	Phone Number	Date

Payroll Classification Code under which you report Employee's wages

Authorized Employer's Signature _____ Date _____

Insurer

Claim Administrator Claim Number	Date Reported to Claim Administrator:	The above information is correct with the following exceptions ☐ (Attach extra sheets if box at right is checked)

Claim Administrator Name	Claim Administrator Address	Claim Administrator FEIN

Insurer Name	Insurer FEIN

Policy Number	Policy Effective Date	Policy Expiration Date

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 09-30-2023
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY FT.BALKNAP INDIAN HEALTH SERVICE MEDICAL RECORDS DEPT.	NAME OF PERSON/ORGANIZATION/FACILITY INTERMOUNTAIN CLAIMS
ADDRESS RR1 Box 67	ADDRESS P.O. Box 4546
CITY/STATE Harlem, MT 59526	CITY/STATE Missoula, MT 59806

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other *(Specify)* _____
☐ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange (IHS/Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☒ Only information related to *(specify)* Part of body -

☐ Only the period of events from _____ to _____
☐ Other *(specify) (CHS, Billing, etc.)* _____
☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years.

_____
(Specify new date)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION	NAME *(Last, First, MI)*	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH

AUTHORIZATION TO RELEASE INFORMATION

TO: Medical Providers	**PATIENT INFORMATION:** Name: Date of Birth: Social Security #: ***-**- Claim No.:	**RELEASE TO:** Intermountain Claims Inc. PO BOX 4546 Missoula, MT 59806

INFORMATION REQUESTED:	**PERTINENT PERIOD OF TIME:**
☒ Copy of All Medical Records ☒ Montana subsequent injury fund records ☐ Mental health information/records* ☐ Drug/Alcohol diagnosis, treatment and/or referral information* ☐ Psychotherapy notes* (*Categories must be initialed by Patient to be included in this Authorization to release information.)	

You are hereby authorized and directed to release relevant health care information (hereinafter "HCI") or other information, whether generated by you or any other source to, Intermountain Claims Inc. its employees and/or agents. The purpose of the release is to allow Intermountain Claims Inc. to investigate and adjust my workers compensation claim. Under §50-16-527(4) of the Uniform Healthcare Information Act, medical information relevant to the claim includes a *past history* of the complaints of, or treatment of, a condition similar to that presented in the claim or other conditions related to the same body part or conditions that might affect recovery**.** This release authorization includes but is not limited to providers' notes, orders, diagnostic studies (radiology, laboratory, EKG, etc.), x-ray films, histories, examinations, treatment records, summaries, hospital records, nurses' documentation, prescriptions, telephone messages, consultations, mental health records, psychiatric and psychological evaluations, diagnostic testing, raw test data, reports, correspondence, and medical bills. ALL information in your possession should be produced unless specifically limited above. I further authorize Intermountain Claims Inc. and its employees and/or agents to have direct contact by any means with any health care provider(s) for administrative purposes without prior notice to me, my authorized representative, agent or my attorney.

A. Claimant's signature: _____ Date: _____

I further authorize Intermountain Claims Inc. and its employees and/or agents to contact my health care provider(s) to provide relevant health care information by telephone, letter, in-person meeting, FAX and/or e-mail without prior notice to me, my authorized representative, agent or my attorney. I understand that I am not required to sign below and that if I do sign immediately below I have done so freely. I understand that if I do not sign below Intermountain Claims Inc. will investigate and adjust my workers' compensation claim.

B. Claimant's signature: _____ Date: _____

This authorization may be revoked in whole or in part at any time by giving written notice to Intermountain Claims Inc., its employees or agent. The revocation is effective from the time it is received by Intermountain Claims Inc., its employees or agent, and does not apply to actions taken by the health care provider or HCI custodian prior to receiving notice of revocation. If not revoked, this authorization terminates thirty (30) months from the date of its execution. A copy of this release is as valid as the original.

I understand that the information that is disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and therefore may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

MEDICAL STATUS FORM

Employer Contact Information (Optional)

Employee Info

Employee's Name (Last, First) _____ Date of Birth (mm/dd/yyyy) _____ Provider Timestamp _____

Claim Number _____ Date of Injury (mm/dd/yyyy) _____ Provider Contact Information _____

Released for Work?

- ☐ Employee Released to Full Duty — Date _____ To _____
- ☐ Employee Released to Modified Duty (See Work Abilities) — Date _____ To _____
- ☐ Employee May Work Limited Hours: Hours Per Day — Date _____ To _____
- ☐ Employee May Work Part-time: — Date _____ To _____
- ☐ Employee Not Released to Work — Date _____ To _____
- ☐ Capacity Duration (Estimate Days): ☐ 1-10 ☐ 11-20 ☐ 21-30 ☐ 30+ ☐ Permanent

Modified Work Abilities

Blank Space = Not Restricted (NR)	L	R	B	Continuous	Frequent	Occasional	Never
Hand/Wrist	L	R	B				
Grasping	L	R	B				
Pushing/Pulling	L	R	B				
Fine Manipulation	L	R	B				
Reaching	L	R	B				
Bending							
Climbing							
Lifting 01-10 lbs.							
Lifting 11-20 lbs.							
Lifting 21-25 lbs.							
Lifting 26-50 lbs.							
Lifting 51-70 lbs.							

Number of Hours Employee May: Sit Stand Walk

List Other Restrictions:

Signatures

Employee Signature	Date
Provider Signature	Date

☐ Copy of Medical Status Form to Employee

Date of Next Visit

Treatment Plan

Employee Progress:	As Expected/Better Than Expected Slower Than Expected
Current Rehab:	PT OT Home Exercise Other:
Surgery:	Not Indicated Possible Planned
Comments:	

- ☐ Treatment Concluded by Provider:
- ☐ Max. Medical Improvement (MMI):
- Care Transferred To:
- Consultation Needed With:
- Study Pending:
- Medications:
- Opioids Prescribed for: Acute Pain Chronic Pain
- Diagnosis:

PHYSICIAN APPOINTMENT QUESTIONNAIRE

Claimant:_____ **DOI:**_____

File #:_____ **Date of Appt:**_____

Case Manager:_____ **Physician:**_____

Work Related Diagnosis:

Objective Medical Findings:

MMI Date, Estimated MMI Date, or Post-op Duration:

Impairment Rating:

Return to Work at Time of Injury Job: (Job analysis received _____Yes _____No

Return to Work, Limited Duty:

Physical Restrictions:

Physician Recommendations/Treatment Plan/Relevant Dates or Timeframes:

_____ _____

Physician **Date**