Tulalip Occupational Safety & Health Administration

How To Process Your Workers' Compensation Insurance Claim

The following are steps needed to insure your claim is processed in a timely manner:

1. Immediately report your injury to your supervisor and pick up an Injury Packet from the Health & Safety Department: Dean Henry – 360-716-4439.

2. Seek medical attention:
   IMPORTANT: Your employer/Tribal First reserves the right to direct your care to a provider of their choice. Please check with your employer, before seeking medical attention, to verify whether or not a provider has already been selected.

3. Have the attending physician completed the Physician's Initial Report included in this packet. You may leave this form with your physician, and he/she will forward it to Tribal First. Your attending physician should also complete the Activity Prescription Form. This form needs to be returned to the Health & Safety Department to be forwarded to Tribal First with your Accident Report.

4. Complete the Employee and Injury/Illness section of the Accident report included in this packet. This should be completed within two days of the injury. Return the completed form to the Health & Safety Department. The Health & Safety Department will complete the bottom portion of the accident report and forward to Tribal First.

5. As soon as Tribal First receives your completed Accident Report, your claim will be processed and a claim number assigned. If Tribal First does not receive a completed form, time loss compensation or medical benefits cannot be provided.

If you have any questions regarding the completion of this packet, please contact the Health & Safety Department at 360-716-4439. You may also contact Tribal First for additional information toll free at 1-877-777-8039 or email NewClaimsWC@tribalfirst.com.

Tulalip Occupational Safety & Health Administration

Workers' Compensation Questions & Answers

Q. Who handles my claim if I am hurt on the job?

A. Tulalip Tribes workers' compensation program is privately insured and is administered by:

Tribal First
1-877-777-8039
Email Us: tribal@tribalfirst.com or
Visit Us: www.TribalFirst.com

The state's workers compensation system does not have jurisdiction. A copy of Tulalip Tribes Workers' Compensation Ordinance is available online:

https://www.codepublishing.com/WA/Tulalip/html/Tulalip09/Tulalip0915.html

Q. If I am unable to work due to my injury, when will compensation begin?

A. If you are off work as a result of your injury, there is a 3 calendar day waiting period in which benefits are not payable, unless 14 consecutive days are missed.

Q. Can I take my personal leave and collect time loss compensation benefits at the same time?

A. If you are off work and elect to take leave, time loss compensation benefits cannot be paid.

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

TRIBAL FIRST
Submit Report To:
newclaimsWC@tribalfirst.com
Fax (360) 413-9291

☐ Fatality

EMPLOYER

1. FIRM NAME: Tulalip Tribes ATTN: Dean Henry
1A. POLICY NUMBER
DO NOT USE THIS COLUMN
2. MAILING ADDRESS (Number and Street, city, Zip): 6406 Marine Drive Tulalip Bay, WA 98271
2A. PHONE NUMBER: 360-716-4439
Case No.
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, city, Zip)
3A. LOCATION CODE
Ownership
4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.
Occupation

EMPLOYEE

5. **EMPLOYEE NAME**
6. SOCIAL SECURITY NUMBER
7. DATE OF BIRTH (mm dd yy) / /
Age
8. **HOME ADDRESS** (Number and Street, city, Zip)
8A. PHONE NUMBER
Daily Hours
9. SEX ☐ MALE ☐ FEMALE
10. OCCUPATION (Regular job title - NO initials, abbreviations or numbers)
11. DATE OF HIRE / /
Days per week
12. EMPLOYEE USUALLY WORKS hours per day / days per week / total weekly hours
12A. EMPLOYMENT STATUS (CHECK APPLICABLE STATUS AT TIME OF INJURY) ◯ regular full time ◯ part-time ◯ temporary ◯ seasonal
12B. DEPARTMENT CODE
Weekly hours
13. GROSS WAGES SALARY $ per
13A. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? ☐ YES, $ per ☐ NO
14. Have you ever injured or received treatment to the same body part? ☐ YES ☐ NO
15. Do you have more than one paying job? ☐ YES ☐ NO
15A. Married? ☐ YES ☐ NO
15B. Dependents? ☐ YES ☐ NO

MEDICAL RELEASE AUTHORIZATION: I hereby authorize my physician, hospital, agency, or organization to disclose to my employer or their representatives, any medical records or other information regarding treatment which has previously been furnished to me.
NOTICE: Indian reservations are sovereign nations and are not subject to the state or federal workers' compensation laws. By completion of this form you are submitting to the sole jurisdiction of the tribe. NOTICE: Making or causing to be made any knowingly false or fraudulent statement written or oral, or purposefully withholding material information in order to receive compensation is unlawful and will result in a denial of benefits, penalties, and/or prosecution.

16. **Employee Signature** **Date**:

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET ILLNESS (mm dd yy) / /
18. TIME INJURY/ILLNESS OCCURRED **A.M.** **P.M.**
19. TIME EMPLOYEE BEGAN WORK **A.M.** **P.M.**
20. IF EMPLOYEE DIED, DATE OF DEATH (mm dd yy) / /
Weekly wage
21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO
22. DATE LAST WORKED (mm dd yy) / /
23. **DATE RETURNED TO WORK (mm dd yy)** / /
24. IF STILL OFF WORK, CHECK THIS BOX ☐
County
25. PAID FULL WAGES FORTHE DAY OF INJRUY OR LAST DAY WORKED? ☐ YES ☐ NO
26. SALARY BEING CONTINUED? ☐ YES ☐ NO
27. DATE OF EMPLOYER'S KNOWLEDGE/ NOTICE OF INJURY/ILLNESS (mm dd yy) / /
28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm dd yy) / /
Nature of injury
29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burn on right arm, tendonitis of left elbow, lead poisoning.
Part of body
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)
30A. COUNTY
30B. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
Source
31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.
32. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ NO
Event
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.
Sec. Source
34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal form, loading boxes onto truck
Extent of injury
35. HOW INJURY/ILLNESS OCCURRED, DESCRIBED SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap metal. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.
36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, Zip)
36A. PHONE NUMBER
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OR HOSPITAL (Number and Street, City, Zip)
37A. PHONE NUMBER

Employer comments/ concerns

Completed by (type or print)	**Signature**	**Title**	**Date**
Dean Henry			

FILING THIS REPORT IS NOT AN ADMISSION OF LIABILITY

MAIL TO TRIBAL FIRST

TRIBAL FIRST

PHYSICIAN'S INITIAL REPORT

1. NAME OF EMPLOYER

ADDRESS

CITY | STATE | ZIP

NAME OF EMPLOYER'S SERVICE REPRESENTATIVE

Tribal First
4160 6th Ave SE, Suite 207
Lacey, WA 98503

EMPLOYER'S TELEPHONE NUMBER

EMPLOYER'S SERVICE REP PHONE
1-877-777-8039

PATIENT INFORMATION

2. NAME OF INJURED WORKER: FIRST MIDDLE LAST

3. WORKER'S TELEPHONE #

4. MAILING ADDRESS

5. SOCIAL SECURITY NUMBER

6. CITY | 7. STATE | 8. ZIP | 9. DATE OF BIRTH (MM/DD/YY)

10. INJURY DATE | 11. TIME | ☐ AM ☐ PM | 12. Have you missed work due to your injury? If so, what dates were you off? From: To:

13. SEX | 14A. MARITAL STATUS | 14B. NUMBER OF DEPENDENTS

15. Describe in detail how your injury or exposure occurred:

Attending Health Care Provider- **START HERE**

22. Date patient first seen by you for this injury/condition:

a. ICD DX CODES | b. Diagnosis - specify Right/Left

16. **MEDICAL RELEASE AUTHORIZATION:**
I HEREBY AUTHORIZE MY HEALTH CARE PROVIDER, HOSPITAL, AGENCY OR ORGANIZATION TO DISCLOSE TO MY EMPLOYER OR MY EMPLOYER'S REPRESENTATIVE ANY RELEVANT MEDICAL RECORDS OR OTHERINFORMATION REGARDING TREATMENT PREVIOUSLY FURNISHED TO ME.

Worker's Signature Date:

23. Are there objective findings to support this diagnosis
☐No ☐Yes, Specify

17. NOTICE: Making any knowingly false or fraudulent statement or withholding information is unlawful.

Worker's Signature: Date:

18. a. Has the worker ever been treated for the same or similar condition?
Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐_____

b. Is there any pre-existing impairment of the injured area?
Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐_____

c. Are there any conditions that will prevent or retard recovery?
Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐_____

d. Was the diagnosed condition caused by this injury or exposure on a more probable than not basis?
No ☐ Yes ☐

24. Referred for Diagnostic Studies
☐No ☐Yes, Specify

19. a. Have you released this worker to return to regular work?
No ☐ Yes ☐ effective date of return to work

b. Have you released this worker to return to light duty?
No ☐ Yes ☐ effective date of return to work

c. What restrictions are placed on light duty return to work?
Lifting _____
Bending_____
Standing_____
Sitting_____
Other_____

d. If not released, how many days off work due to the work injury?

25. Treatment Recommendations:

20. Licensed Healthcare Provider must sign before report is accepted

Signature: Date:

Phone:

21. Attending Healthcare Provider Name:

Address:

City: State: ZIP:

26. Referred Healthcare Provider (Patient Referred for Follow-Up)

Address:

Phone:

15. IRS Account #

DO NOT SEND THIS FORM TO LABOR & INDUSTRIES

Tribal First
4160 6th Ave SE, Suite 207
Lacey, WA 98503
FAX: (360) 413-9291

ACTIVITY PRESCRIPTION FORM (APF)

TRIBAL FIRST

General Info

Worker's Name:	Visit Date:	Claim Number:
Health Care Provider's Name (printed):	Date of Injury:	Diagnosis:

Required: Release for work? *Check at least one*

☐ Worker is **released** to the job of injury without restrictions on (date): ____/____/____ *Skip to "Plans" section below.*

☐ Worker **may perform modified duty**, if available, from (date):
____/____/____ to ____/____/____
☐
____/____/____ to ____/____/____

☐ Worker ***is* working** modified duty or limited hours
Please estimate capacities below and provide key objective finding at right.

☐ Worker not released to any work from (date): ___/___/___ to ___/___/___
☐ Prognosis poor for return to work at the job of injury at any date
☐ May need assistance returning to work

Required: Key Objective Finding(s)

Capacities apply 24/7, please estimate capacities below and provide key objective findings at right. Note - these restrictions should be followed outside of work as well as at work

Required: Estimate what the worker can do *Unless released to JOI*

Capacity duration (estimate days): ☐**1-10** ☐**11-20** ☐**21-30** ☐**30+** ☐**permanent**

Worker can: (Related to work injury.) Blank space = Not restricted	Never	Seldom 1-10% 0-1 hour	Occasional 11-33% 1-3 hours	Frequent 34-66% 3-6 hours	Consistent 67-100% Not restricted
Sit					
Stand / Walk					
Climb (ladder / stairs)					
Twist					
Bend / Stoop					
Squat / Kneel					
Crawl					
Reach **L**eft, **R**ight, **B**oth					
Work above shoulders **L R B**					
Keyboard **L R B**					
Wrist (flexation/extension) **L R B**					
Grasp (forceful) **L R B**					
Fine manipulation **L R B**					
Operate foot controls **L R B**					
Vibratory tasks; high impact					
Vibratory tasks; low impact					

Lifting / Pushing	Never	Seldom	Occas.	Frequent	Constant
Example	50 lbs	20 lbs	10 lbs	0 lbs	0 lbs
Lift **L R B**	____lbs	____lbs	____lbs	____lbs	____lbs
Carry **L R B**	____lbs	____lbs	____lbs	____lbs	____lbs
Push / Pull **L R B**	____lbs	____lbs	____lbs	____lbs	____lbs

Other restrictions/Instructions:

Employer Notified of Capacities?
☐Yes ☐No
Modified Duty Available?
☐Yes ☐No
Date Contact: ____/____/____
Name of Contact:_____
Notes:

Note to Claim Manager:

New diagnosis:_____
Opioids prescribed for: ☐Acute pain ☐Chronic pain

Required: Plans

Worker Progress: ☐As expected / better than expected.
☐Slower than expected. *Address in chart notes*

Current Rehab: ☐PT ☐OT ☐Home exercise
☐Other_____

Surgery: ☐Not Indicated ☐Possible ☐Planned
Comments:

☐Next scheduled visit in: _____ days, _____ weeks.
☐Treatment concluded (MMI)
Any permanent partial impairment?
☐Yes ☐No ☐Possibly
If you are qualified, please rate impairment for your patient.
☐Will rate ☐Will refer ☐Request IME
Care transferred to:_____
Consultation needed with:_____
Study pending:_____

Sign

Signature (**Required**): _____ ( )_____-_____ Date: ____/____/____
☐Doctor ☐ARNP ☐PA-C Phone number

☐Copy of APF given to worker ☐Discussed with worker