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 _____ (_____) _____
Witness Name Phone

Did you seek medical treatment for this occurrence? ☐ Yes ☐ No If Yes, List name, phone and address of hospital / physician:

_____

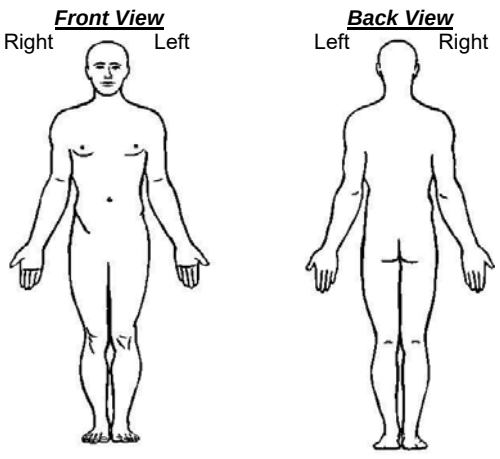
***Employees who live in the network service area must seek medical attention from any physician or clinic within the Workers' Compensation Provider Network**

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)

_____

_____

_____

_____

_____

_____

_____

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**

For more information please contact the Office of Risk Management: Workers' Compensation Insurance at 512.499.4645

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

PLEASE COPY THIS FORM AND RETURN TO EMPLOYEE

This employee has claimed a work related injury and may be covered by Workers' Compensation Insurance through the University of Texas System.

The University of Texas System Administration is a self-funded employer. Claims are processed through the University of Texas System in Austin.

It is an administrative violation to bill injured employee directly for Workers' Compensation treatment. See Section 413.042 of Texas Labor Code.

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.

THIS FORM DOES NOT CERTIFY COMPENSABILITY OR GUARANTEE PAYMENT

Please submit bills, medical reports, or questions to:

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

Pharmacy Instructions

The University of Texas System has partnered with Mitchell ScriptAdvisor to make filling prescriptions easy.

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.

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.

Processor: **Mitchell**

PCN: **MPS**

Group: **MPS001150TC**

BIN: **019082**

Mitchell Help Desk: **877-232-6520**

ID: __ __ __ __ __ __ __ __ __ __ __ __

Date of injury (MMDDYY)+Date of Birth (MMDDYY)

(ID Example: MMDDYYMMDDYY)

Day Supply is limited to **7** days for a new injury

Injured Employee:

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS

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.

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.

If you are denied medication(s) at the pharmacy, please call 877-232-6520.

MODIFIED DUTY MAY BE AVAILABLE, PLEASE REACH OUT TO YOUR SUPERVISOR

Employer Representative Phone Date