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:

_____

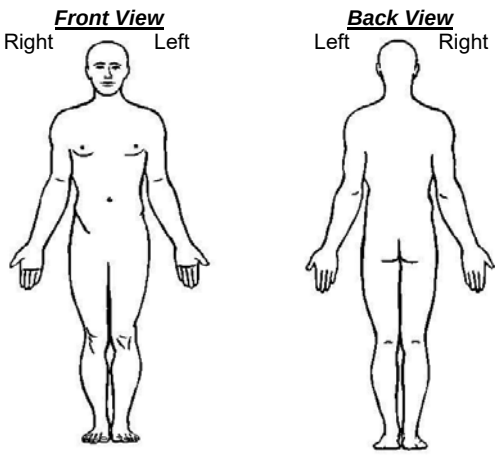
***Employees who live in the network service area must seek medical attention from any physician or clinic within the Workers' Compensation Provider Network**

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

RxBridge

THE UNIVERSITY OF TEXAS SYSTEM ADMINISTRATION
FIRST FILL PRESCRIPTION CARD

Upon receiving prescriptions for a work-related injury for one of your employees, please provide the injured worker with a copy of this instruction sheet or ask them to text **UTS00** to toll free 833-FRSTFILL (833-377-8345). The injured worker will complete the process and then present their billing information via mobile device.

Please follow the below instructions to obtain your First Fill Prescription Card.

Text
UTS00
to 833-377-8345

How it Works

01

Text
Text **UTS00** to toll free
833-FRSTFILL (833-377-8345)

02

Follow the On-Screen Step by Step Instructions
Step 1: Text your First and Last Name
Step 2: Text your Date of Injury
Step 3: Confirm Information

03

Receive First Fill Card
You will receive an image of your prescription card right to your phone.

04

Fill Your Prescriptions
Present your First Fill Prescription Card along with your injury related prescription(s) to your local pharmacy.

If you encounter any problems filling your prescriptions or to find a participating retail pharmacy, please call RxBridge at 833-RxBridge (833-792-7434) or use our pharmacy locator at www.RxBridge.com