THE SHOSHONE-PAIUTE TRIBES
OF THE DUCK VALLEY INDIAN RESERVATION
P.O. Box 219 Owyhee, NV 89832
(208) 759-3100
www.shopaitribes.org

Shoshone-Paiute Tribes
Human Resources

How To Process Your Workers' Compensation Insurance Claim

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

1. Immediately report your injury to your supervisor and pick up an Injury Packet from the Human Resources and complete the required drug test.

2. Seek Medical attention.

3. Have the attending physician complete the Physicians Initial Report included in this packet. Your attending physician should also complete the Activity Prescription Form. These forms need to be returned to Human Resources to the attention of Gonnie Mendez. This form will be forwarded to Tribal First with your Accident Report.

4. Complete the upper portion of the Accident Report included in this packet. This should be completed within two days of the injury. **Return the completed form to the Human Resources.** Human Resources will complete the bottom portion of the accident report, and the Employer Report of Occupational Injury or Illness form and will forward all forms to Tribal First.

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

If you have any questions or assistance regarding the completion of this packet, please contact Gonnie Mendez, Assistant HR Director/Benefits Coordinator at (208) 759-3100, ext. 1237. You may contact the claims examiner for additional information at Tribal First at 1-800-552-8921.

MAIL TO TRIBAL FIRST

TRIBAL FIRST

PHYSICIAN'S INITIAL REPORT

1. NAME OF EMPLOYER
Shoshone-Paiute Tribes

ADDRESS
P.O. Box 219

CITY: Owyhee | STATE: NV | ZIP: 89832

NAME OF EMPLOYER'S SERVICE REPRESENTATIVE

Tribal First
PO Box 609015
San Diego, CA 92160

EMPLOYER'S TELEPHONE NUMBER: 208-759-3100, Ext. 1224

EMPLOYER'S SERVICE REP PHONE: 1-800-552-8921

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

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

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

25. Treatment Recommendations:

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

Address:

Phone:

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:

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:

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 ☐

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?

20. Licensed Healthcare Provider must sign before report is accepted

Signature: Date:

Phone:

21. Attending Healthcare Provider Name:

Address:

City: State: ZIP:

15. IRS Account #

DO NOT SEND THIS FORM TO LABOR & INDUSTRIES

EMPLOYEE'S CLAIM FOR WORKERS' INJURY BENEFITS

If you are injured or become ill because of your job, you may be entitled to workers' injury benefits. Please complete this form and submit it to your employer.

NOTICE: Indian Reservations are sovereign nations and are not subject to State or Federal Workers' Compensation laws. By completion of this form you are submitting to the sole jurisdiction of the Tribe.

Employee:

1. Name: _____ Today's Date: _____
2. Home Address: _____
3. City: _____ State: _____ Zip: _____
4. Date of injury: _____ Time of injury: _____ *a.m.* _____ *p.m.*
5. Address and description of where injury happened. _____

   _____
6. Describe injury and part of body affected. _____

   _____
7. First Aid Only? ☐ Yes ☐ No
8. Social Security Number: _____
9. Signature of employee: _____

Employer - complete this section and give the employee a copy immediately as a receipt.

10. Name of Employer: _____
11. Address: _____
12. Date employer first knew of injury: _____
13. Date claim form was provided to employee: _____
14. Date employer received claim form: _____
15. Name of insurance carrier of adjusting agent: TRIBAL FIRST CLAIMS MANAGEMENT
16. Insurance Policy Number: _____
17. Signature of employer representative: _____
18. Title: _____ Telephone: _____

Employer: Date this form and provide copies to TRIBAL FIRST CLAIMS ADMINISTRATION and the employee, dependent or representative who filed the claim.

NATIVE AMERICAN TRIBAL INSURANCE PROGRAM

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

TRIBAL FIRST CLAIMS ADMINISTRATION

P.O. BOX 609015
SAN DIEGO, CA 92160
FAX: (619) 699-0978

☐ Fatality

EMPLOYER

1. FIRM NAME	1A. POLICY NUMBER	DO NOT USE THIS COLUMN
2. MAILING ADDRESS (Number and Street, city, Zip)	2A. PHONE NUMBER	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.	5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.	Industry
6. TYPE OF EMPLOYER ☐ PRIVATE ☐ STATE ☐ CITY ☐ COUNTY ☐ SCHOOL DIST. ☐ OTHER GOVERNMENT - SPECIFY		Occupation

EMPLOYEE

7. EMPLOYEE NAME	8. SOCIAL SECURITY NUMBER	9. DATE OF BIRTH (mm dd yy)	Sex
10. HOME ADDRESS (Number and Street, city, Zip)		10A. PHONE NUMBER	Age
11. SEX ☐ MALE ☐ FEMALE	12. OCCUPATION (Regular job title - NO initials, abbreviations or numbers)	13. DATE OF HIRE	Daily Hours
14. EMPLOYEE USUALLY WORKS hours per day / days per week / total weekly hours	14A. EMPLOYMENT STATUS (CHECK APPLICABLE STATUS AT TIME OF INJURY) regular full time / part-time / temporary / seasonal	14B. DEPARTMENT CODE	Days per week
15. GROSS WAGES SALARY $ per	16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? ☐ YES, $ per ☐ NO		Weekly hours

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	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 FOR DAY OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO	26. SALARY BEING CONTINUED ☐ YES ☐ NO	27. DATE OF EMPLOYER'S KNOWLEDGE	28. DATE EMPLOYEE WAS	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)	31A. 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		

Completed by (type or print)	Title	Date

Tribal First
PO Box 609015
San Deigo, CA 92160
FAX: 858-277-4519

ACTIVITY PRESCRIPTION FORM (APF)

General Info

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

Required: Released 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 findings 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
Capacities apply 24/7, please estimate capacities below and provide key objective findings at right.

Required: Key Objective Finding(s)

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	Constant 67-100% Not restricted
Sit					
Stand / Walk					
Climb (ladder / stairs)					
Twist					
Bend / Stoop					
Squat / Kneel					
Crawl					
Reach Left, Right, Both					
Work above shoulders L, R, B					
Keyboard L, R, B					
Wrist (flexion/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 of contact: ___/___/___
Name of contact:_____
Notes:

Note to Claim Manager:

New diagnosis:_____
Opioids prescribed for: ☐ Acute pain or ☐ 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, Max. Medical Improvement (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