

The Shoshone Paiute Tribes of the Duck Valley Indian Reservation Human Resources Department

P.O. BOX 219 Owyhee, NV 89832
208-759-3100 ext. 1236
hr@shopai.org



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 Human Resources Department and complete the required drug test.
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 complete the Physicians Initial Report included in this packet. You may leave this form with your physician, and he/she will forward it to the insurance company listed on the form. Your attending physician should also complete the Activity Prescription Form. This form needs to be returned to Human Resources to the attention of Linda Gumphrey. 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 Department.** Human Resources will complete the bottom portion of the Accident Report and forward it 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, the time loss or medical benefits cannot be provided.**

If you have any questions regarding the completion of this packet please contact Linda Gumphrey, Human Resources Director, at (208) 759-3100, ext. 1238. You may contact the claims examiner for addition information at Tribal First at 1-800-552-8921

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.

MAIL TO TRIBAL FIRST



PHYSICIAN'S INITIAL REPORT

1. NAME OF EMPLOYER Shoshone-Paiute Tribes			PATIENT INFORMATION		
ADDRESS P.O. Box 219			2. NAME OF INJURED WORKER: FIRST MIDDLE LAST		3. WORKER'S TELEPHONE #
CITY Owyhee	STATE NV	ZIP 89832	4. MAILING ADDRESS		5. SOCIAL SECURITY NUMBER
NAME OF EMPLOYER'S SERVICE REPRESENTATIVE Tribal First PO Box 609015 San Diego, CA 92160			6. CITY	7. STATE	8. ZIP
			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
EMPLOYER'S TELEPHONE NUMBER 208-759-3100, Ext. 1224	EMPLOYER'S SERVICE REP PHONE 1-800-552-8921		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:			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 OTHER INFORMATION REGARDING TREATMENT PREVIOUSLY FURNISHED TO ME. Worker's Signature _____ Date: _____		
a. ICD DX CODES	b. Diagnosis - specify Right/Left				
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: _____		
24. Referred for Diagnostic Studies ☐ No ☐ Yes, Specify			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 ☐		
25. Treatment Recommendations:			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?		
26. Referred Healthcare Provider (Patient Referred for Follow-Up)			20. Licensed Healthcare Provider must sign before report is accepted Signature: _____ Date: _____		DO NOT SEND THIS FORM TO LABOR & INDUSTRIES
Address:			21. Attending Healthcare Provider Name: Address:		
Phone:			City: _____ State: _____ ZIP: _____		
			15. IRS Account #		

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): ____/____/____ <i>Skip to "Plans" section below.</i>		Required: Key Objective Finding(s)
	☐ Worker may perform modified duty , if available, from (date): ____/____/____ to ____/____/____ ☐ ____/____/____ to ____/____/____ ☐ Worker is working modified duty or limited hours <i>Please estimate capacities below and provide key objective findings at right.</i>		
	☐ 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 <i>Capacities apply 24/7, please estimate capacities below and provide key objective findings at right.</i>		

Required: Estimate what the worker can do Unless released to JOI	Capacity duration (estimate days): ☐ 1-10 ☐ 11-20 ☐ 21-30 ☐ 30+ ☐ permanent						Other Restrictions / Instructions: 																																																																																																					
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Required: Plans	Worker progress: ☐ As expected / better than expected. ☐ Slower than expected. <i>Address in chart notes</i> 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): _____ () _____ ☐ Doctor ☐ ARNP ☐ PA-C Phone number	Date: ____/____/____
	☐ Copy of APF given to worker ☐ Discussed with worker	