

FIRST REPORT OF INJURY OR ILLNESS

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION**

For assistance call 1-800-342-1741
or contact your local EAO Office
Report all deaths within 24 hours 1-800-219-8953 or (850) 922-8953

RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last)		Social Security Number	Date of Accident (Month-Day-Year)	Time of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM
HOME ADDRESS Street/Apt #: _____ City: _____ State: _____ Zip: _____		EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)		
TELEPHONE Area Code Number				
OCCUPATION		INJURY/ILLNESS THAT OCCURRED	PART OF BODY AFFECTED	
DATE OF BIRTH ____/____/____	SEX <input type="checkbox"/> M <input type="checkbox"/> F			

EMPLOYER INFORMATION

NAME: <u>Nova Southeastern University</u> COMPANY		FEDERAL I.D. NUMBER (FEIN) 59-1083502	DATE FIRST REPORTED (Month/Day/Year)
D. B. A.: <u>Same</u>		NATURE OF BUSINESS Education	POLICY/MEMBER NUMBER 2499309
Street: <u>3301 College Avenue</u>			
City: <u>Ft Lauderdale</u> State: <u>Florida</u> Zip: <u>33314</u>			
TELEPHONE Area Code Number		DATE EMPLOYED ____/____/____	PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYER'S LOCATION ADDRESS (If different) Street: _____ City: _____ State: _____ Zip: _____		LAST DATE EMPLOYEE WORKED ____/____/____	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? <input type="checkbox"/> YES
LOCATION # (If applicable) _____		RETURNED TO WORK <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DATE ____/____/____	LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP ____/____/____
PLACE OF ACCIDENT (Street, City, State, Zip) Street: _____ City: _____ State: _____ Zip: _____		DATE OF DEATH (If applicable) ____/____/____	RATE OF PAY <input type="checkbox"/> HR <input type="checkbox"/> WK \$ _____ PER <input type="checkbox"/> DAY <input type="checkbox"/> MO
COUNTY OF ACCIDENT _____		AGREE WITH DESCRIPTION OF ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	Number of hours per day _____ Number of hours per week _____ Number of days per week _____
Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234, Section 440.105(7), F.S. I have reviewed, understand and acknowledge the above statement.		NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL	
EMPLOYEE SIGNATURE (If available to sign) _____ DATE _____			
EMPLOYER SIGNATURE _____ DATE _____		AUTHORIZED BY EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO	

CLAIMS-HANDLING ENTITY INFORMATION

<input type="checkbox"/> 1 (a) Denied Case - DWC-12, Notice of Denial Attached	<input type="checkbox"/> 2. Medical Only which became Lost Time Case (Complete all required information in #3)
<input type="checkbox"/> 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached	Employee's 8TH Day of Disability ____/____/____
	Entity's Knowledge of 8TH Day of Disability ____/____/____
<input type="checkbox"/> 3. Lost Time Case - 1st day of disability ____/____/____	Full Salary in lieu of comp? YES Full Salary End Date ____/____/____
Date First Payment Mailed ____/____/____	AWW _____ Comp Rate _____
<input type="checkbox"/> T.T. <input type="checkbox"/> T.T. - 80% <input type="checkbox"/> T.P. <input type="checkbox"/> L.B. <input type="checkbox"/> P.T. <input type="checkbox"/> DEATH <input type="checkbox"/> SETTLEMENT ONLY	
Penalty Amount Paid in 1st Payment \$ _____	Interest Amount Paid in 1st Payment \$ _____

REMARKS:			INSURER NAME
INSURER CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE	CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE Cannon Cochran Management Services, Inc. PO Box 948399 Maitland FL 32794-8399 866-291-0194 407-660-5600 Fax: 217-477-6946 FCURMAmail@ccmsi.com
SERVICE CO/TPA CODE #	CLAIMS-HANDLING ENTITY FILE #		

DWC-1 Purpose and Use Statement

The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.

WORKERS' COMPENSATION TREATMENT AUTHORIZATION FORM

This is a Worker's Compensation Treatment Authorization Form. This Form is not a guarantee of eligibility or compensability for Workers' Compensation Benefits.

To be completed by employer (please print)

Account Number: F45

Employer Name: Nova Southeastern University

Employer Address: 3301 College Avenue, Ft. Lauderdale, Florida 33314

Employee Name: _____

Social Security Number: _____ Date of Injury: _____

Type of Injury: _____

Body Part Injured: _____

Supervisor issuing form: Dr. Charmaine Beckford (T) 954-262-5404* 954-262-6860-(F)

Supervisors: Please give this completed form to the injured employee to take with them to the physician.

This form is for one time use, only on this date _____.

Providers: You must call Cannon Cochran Management Services, Inc. toll free at 1-866-291-0194 prior to any additional treatment/admission or referral, other than an emergency. In an emergency, notification to CCMSI is required within 24 hours.

Send Medical Bills To:

Cannon Cochran Management Services, Inc.
PO Box 948399 | Maitland | FL 32794-8399
1-866-291-0194 | 407-660-5600 | Fax: 217-477-6946 | FICURMAmail@ccmsi.com



FICURMA Workers' Compensation Prescription Information

Employer:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

	 
Employee Name:	
Group#:	P2KA
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	003858
Day supply is limited to 14 days for a new injury.	
myMatrixx Help Desk: (877) 804-4900	

Employee:

FICURMA has partnered with **myMatrixx** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 64,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist:

Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900



AUTHORIZATION FOR MEDICAL RECORDS AND COMMUNICATION RELEASE

Name: _____ Date of Birth: _____ Social Security #: _____

I hereby authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of my mental or physical health, history, condition or wellbeing, to supply such information to my employer or its insurance carrier, claims administrator or attorneys.

I specifically authorize any treating physician or medical care provider to communicate orally or in writing with my employer or its insurance company, claims administrator, rehabilitation or medical management consultant or attorneys as to my care and treatment, and as to any other issues including diagnosis, prognosis, causal connection of care and treatment to my work injury or duties, and ability to work. I hereby waive my physician-patient privilege. In conjunction with this, I also authorize any treating physician or medical provider to review any additional materials provided to them.

A photocopy of this authorization shall be as valid as the original. This release shall remain valid for the length of my claim.

Note: Workers' Compensation Requests Are Exempt From HIPAA. Pursuant to 45 CFR, Sect. 164.512(1) a covered entity may without penalty under HIPAA disclose protected health information to the extent necessary to comply with the law relating to workers' compensation.

NAME-PLEASE PRINT

SIGNATURE

DATE



False and Fraudulent Claim Warning

Please read the following information carefully. This form must be signed and returned within 30 days of the date it was received, stating that you have reviewed, understand and acknowledge the statement of benefits and/or payments shall be suspended until such signature obtained.

Workers' Compensation fraud includes but is not limited to the following:

- Requesting and/or receiving temporary total, temporary partial, permanent total disability or impairment benefits while working for gain as an employee of a business, independent contractor, yourself or a business and not reporting that income to the insurance company.
- Making a false or written statement and/or submitting false documents to your employer, your physician and/or the insurance company or their representatives for the purpose of filing or supporting a claim for workers' compensation benefits.
- Misrepresenting facts concerning an industrial accident, injury or illness to your employer, your physician and/or the insurance company or their representatives.
- Failing to report earnings when requested to do so by the insurance company.
- Selling your personal information to third parties for use of misrepresenting facts to any medical provider or insurance company.

Florida

Any person who knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud punishable as provided in Florida Statute 817.234.

I have reviewed, understand and acknowledge the above. This information is true and correct to the best of my knowledge.

Workers Name:

Please type or print

Claim #: _____ Employee: _____

Employer: _____

Employees' Address: _____

Phone: _____

Workers' Signature: _____ Date: _____

Cannon Cochran Management Services, Inc.

PO Box 948399 | Maitland | FL 32794-8399

866-291-0194 | 407-660-5600 | Fax: 217-477-6946 | FICURMAmail@ccmsi.com

Workers' Compensation Witness Report Form (To be completed by witness only)

Name of injured employee: _____

Name of witness: _____

Telephone # of Witness _____

Location where incident occurred: _____

Date of incident: _____ Time of incident: _____

1. What were you (the witness) doing at the time of the incident?

2. How and when did you become aware of the incident?

3. What did you hear at the time of the incident?

4. Describe what you saw at the time of the incident:

5. Who else was present?

6. Please relate any additional information you have pertaining to the incident:

Witness's signature: _____ Date signed: _____

