Instructions for Work Accident

- Complete the: **First Report of Injury**.
  - Complete **Employee's Statement**.
  - Complete **Anatomy Chart form** by circling injured part of body.
  - Complete, Sign and date bottom portion of **Authorization to Release Medical Information** form.
- Return completed forms to supervisor or email to rleonhardt@minutemenhr.com
- Report to nearest healthcare provider for treatment.
- After treatment has been rendered, report back to your supervisor with all paperwork or email to rleonhardt@minutemenhr.com
- Any questions concerning completing the forms contact information is below.

PLEASE SUBMIT INJURY REPORT TO

Roger Leonhardt

MINUTEMEN EOR
3740 Carnegie Avenue
Cleveland, OH 44115
Toll Free: 877.541.8154
Main: 216.539.9582
Fax: 216.426.2254

DIRECT: 216-539-9582

rleonhardt@minutemenhr.com

3740 Carnegie Avenue
Cleveland, Ohio 44115
Phone 216-539-9582
Fax 216-426-2553

EMPLOYEE'S STATEMENT

I,____________________________certify that on ____________, 20 ____at _________________(a.m. or p.m.), I
(Name) (Date) (Time)

sustained an injury to my ____that occured as follows:
(Part of Body)

(Describe the incident in detail, stating part of body injured) ____

____

____

____

Has this body part been previously injured? ☐ Yes ☐ No If yes, when?__________________________

Place incident occurred (Dept.,Plant,etc.)____

Did the incident occur while you were working (on the clock)? ☐ Yes ☐ No

Did the incident occur while you were performing your reguarly assigned job/duty? ☐ Yes ☐ No

Did the incident occur on employer's property? ☐ Yes ☐ No

Names of Witnesses: ____

To whom did you report the accident? ____

Date and Time reported____

Hospital and/or Doctor ____

Address of Hospital or Doctor ____

____

Employee address ____

____

Social Security Number _______ - _____ - _________ Phone Number _________________________________

Date of birth _________________________________Date of Hire _______________________________________

Occupation __________________________________Supervisor____

Signature of Employee ____ Date _________________

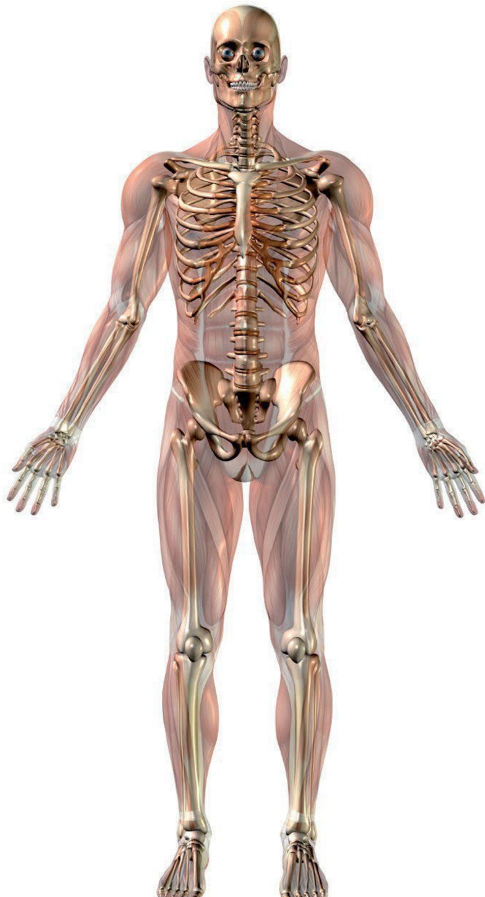
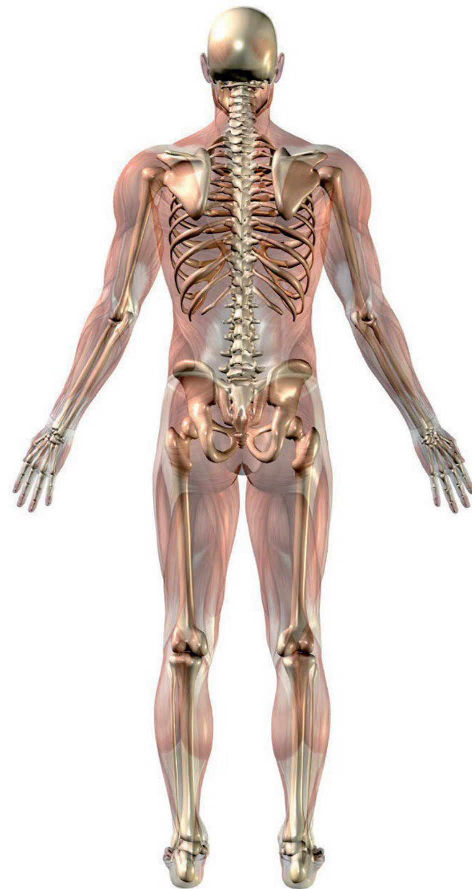
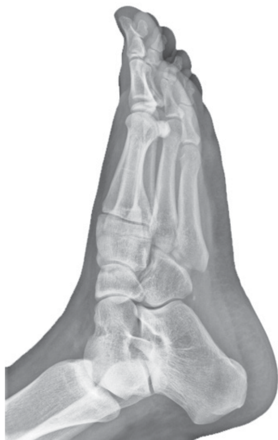
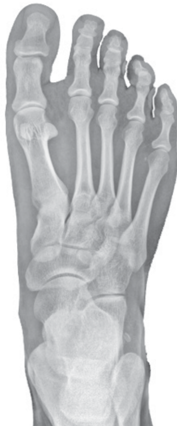
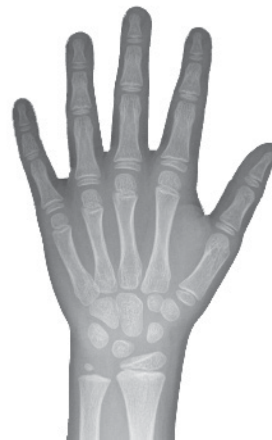
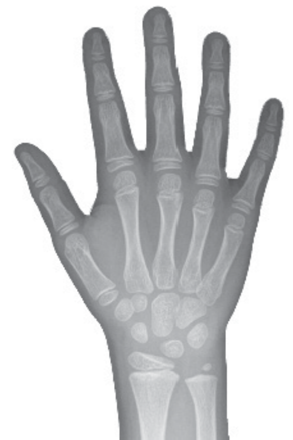
MINUTEMEN
EOR SOLUTIONS
WORKFORCE MANAGEMENT SERVICES

3740 Carnegie Avenue
Cleveland, Ohio 44115
Phone 216-539-9582
Fax 216-426-2553

ANATOMY FORM

Instructions for Employee:
Please circle the injured body part(s) then sign and date this form.

______________________________________ ____________________________
Signature of Claimant Date

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Cleveland, Ohio 44115
Phone 216-539-9582
Fax 216-426-2553

WITNESS STATEMENT

Name of injured worker: ____________________

Date of injury ____________ Time of injury: ____________(a.m. or p.m.)

Place of injury: ____________________

Description of injury: ____________________

Description of how injury occurred: ____________________

____

Did you see the accident? ☐ Yes ☐ No

Describe how you became aware of the incident ____________________

____

How did the injured person describe the accident to you? ____________________

____

Who else was aware of the accident? ____________________

Was the injured employee on the clock or on duty when the incident occurred?____________________

Describe any known previous injuries or problems this person has with the same part of the body:

____

Any other information you wish to provide? ____________________

____

Witness's Name ____________________Witness's Address ____________________

Witness's Phone: ____________________

Signature of Witness: ____________________ Date: ____________

STANDARD AUTHORIZATION FORM

Fields marked with an asterisk (*) are required to be completed. Failure to provide additional identifying information in Section I may result in the inability to respond to this request. This form is not a patient access request under 45 CFR 164.524. *Records released pursuant to this authorization may include information concerning testing, diagnosis or treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault.*

FORM A – AUTHORIZATION FOR RELEASE OF INFORMATION FROM COVERED ENTITIES (OTHER THAN PART 2 PROGRAMS)

Section I				
First Name*	M.I.	Last Name*	Date of Birth*	Social Security Number
Address		City	State	Zip Code

I hereby authorize the disclosure of health information about the above individual as follows.

Section II		
Disclosing Entity* *(Covered Entity such as a health plan/insurer or provider)*		
Address		Telephone Number
City	State	Zip Code
Recipient (Person or Entity) *		
Contact Information *(e.g. telephone number, email address, fax number, street address, etc.)*		

Section III

Reason for Disclosure*

Health information to be disclosed*

Specify time period, if desired:
Release only information from the period ________________ *(mm/dd/yyyy)* to _________________ *(mm/dd/yyyy)*

Section IV

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.

Expiration Date or Event ______________________ *(mm/dd/yyyy)*

- I understand that I may not be denied treatment, payment, and enrollment in the health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law.
- I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164].

Signature of Individual*	**Date*** *(mm/dd/yyyy)*
Signature of Personal Representative (if applicable)* *(identify relationship to individual below)*	**Date*** *(mm/dd/yyyy)*

Relationship of Personal Representative to Individual *(Personal representative shall submit proof of authority to the disclosing entity)*
☐ Parent ☐ Legal Guardian ☐ Healthcare Power of Attorney ☐ Executor/Administrator ☐ Other ☐ N/A

For administrative use only:

Method of Delivery (e.g. paper, fax, electronic,)	**Date Released**

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar

MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)
NAME OF BENEFICIARY
JANE DOE
MEDICARE CLAIM NUMBER SEX
000-00-0000-A FEMALE
IS ENTITLED TO EFFECTIVE DATE
HOSPITAL (PART A) 07-01-1986
MEDICAL (PART B) 07-01-1986
SIGN HERE
SAMPLE

Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	☐ Yes	☐ No
If yes, please complete the following. If no, proceed to Section II.		
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card if available.)*		
Medicare Claim Number:	**Date of Birth** (Mo/Day/Year)	– –
Social Security Number: (If Medicare Claim Number is Unavailable) – –	**Sex**	☐ Female ☐ Male

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) **Claim Number**

Name of Person Completing This Form If Claimant is Unable (Please Print)

Signature of Person Completing This Form **Date**

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Section III

______________________________________ ______________________________

Claimant Name (Please Print) **Claim Number**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

____

____

____

____

______________________________________ ______________________________

Signature of Person Completing This Form **Date**