Worker's and Health Care Provider's Report for Workers' Compensation Claim, Form 827

Instructions and definitions

Ask the worker to complete this form **ONLY** in the following circumstances:

- First report of injury or disease
- Request for acceptance of a new or omitted medical condition
  "Omitted" refers to a condition the worker thinks should have been included among the conditions accepted by the insurer.
- Report of aggravation of original injury
  "Aggravation" means the actual worsening of an accepted condition resulting from the original injury.
- Notice of change of attending physician or nurse practitioner
  This means the new provider will be primarily responsible for treatment. Being primarily responsible does NOT include:
  - *Treatment on an emergency basis*
  - *Treatment on an "on-call" basis*
  - *Consulting*
  - *Specialist care (unless the specialist assumes complete control of care)*
  - *Exams done at the request of the insurer or the Workers' Compensation Division*

If the worker completes and signs Form 827, give the worker copies of Form 827 and Form 3283 (included with this packet) immediately.

Do **NOT** ask the worker to complete this form for the following:

- Progress report
- Closing report
- Palliative care request
  Palliative care is care that makes the worker feel better but does not cure an unwanted condition. The worker must be in the workforce or in a vocational program to be eligible for palliative care. The following are not palliative care:
  - *Prescriptions, prosthetics, braces, and doctors' appointments to monitor them*
  - *Diagnostic services*
  - *Life-preserving treatments*
  - *Curative care to stabilize an acute waxing and waning of symptoms*
  - *Services to a permanently and totally disabled worker*

  When requesting palliative care approval from the insurer, include the following in your request:
  - *Who will provide the care*
  - *Modalities ordered, including frequency and duration*
  - *How the need for care is related to the accepted conditions*
  - *How the care will enable the worker to continue current work or vocational training*

For these reports, you have the option of filing Form 827, submitting chart notes, or submitting a report that includes data gathered on Form 827.

"Regular work" under "Work ability status" means the job the worker held at the time of injury.

If you have questions about completion of Form 827, please contact a benefit consultant at 800-452-0288.

827

DEPARTMENT OF CONSUMER & BUSINESS SERVICES — *Workers' Compensation Division*

Worker's and Health Care Provider's Report for Workers' Compensation Claims

OPTIONAL — WCD employer no.: | Policy no.:

Note to Provider: **Ask the worker to complete this form ONLY for the four filing reasons in the worker's section; do not have the worker complete or sign form if this is a progress report, closing report, or palliative care request.**

Dept. Use: Ins. no. | Occ. | Nature | Part | Event | Source | Assoc. object

Worker or provider

Worker's legal name, street address, and mailing address:

Phone:

Language preference: | Male/female ☐ ☐ | Social Security no. (see Form 3283):

Claim no. (if known): | Date/time of original injury:

Date of birth: | Occupation: | Last date worked:

Employer at time of original injury — name and street address:

Phone:

Health insurance company name and phone:

Workers' compensation insurer's name, address:

Worker

Worker: Check reason for filing this form, answer questions (if any), and sign below.

☐ **First report of injury or disease** (Do not complete or sign if you do not intend to make a claim.)
Have you injured the same body part before? ☐ Yes ☐ No If yes, when: _____

☐ **Request for acceptance of a new or omitted medical condition on an existing claim**
Condition: _____

☐ **Notice of change of attending physician or nurse practitioner**
Reason for change: _____

☐ **Report of aggravation of original injury (actual worsening of underlying condition)**

Check here if you have more than one job. ☐

Describe accident:

By signing this form, I authorize health care providers and other custodians of claim records to release relevant medical records. I certify that the above information is true to the best of my knowledge and belief. (See back of form.)

X _____ ***Worker's signature*** _____ ***Date***

Provider

Provider: If worker initiated this report, give worker a copy immediately.

If the worker filed this report for:

- **First report** of injury or illness – **Send this form to the workers' compensation insurer within 72 hours of visit.**
- **New or omitted** medical condition – Attach chart notes, including diagnostic codes. **Send this form to the insurer within five days of visit.**
- **Change of attending physician** or nurse practitioner – By signing this form, you acknowledge that you accept responsibility for the care and treatment of the above-named worker. **Send this form to the insurer within five days** after the change or the date of first treatment. Check the following, if applicable: ☐ **I request insurer to send its records.**
- **Aggravation of original injury** – Sign this form and **send it to insurer within five days of visit.**

If filing for progress report, closing report, or palliative care request, check the appropriate box below.

☐ **Progress report** ***OR*** ☐ **Closing report** (See instructions in Bulletin 239.)

☐ **Palliative care request** – Complete remainder of form, except Section b. **Attach a palliative care plan**; state how care relates to the compensable condition, how care will enable worker to continue work or training, adverse effect on worker if care not provided.

To get the name and address of the insurer, call the Workers' Compensation Division's Employer Index 503-947-7814, or visit online:
WorkCompCoverage.wcd.oregon.gov
To order supplies of this form, call 503-947-7627.

a

Date/time of first treatment: | Last date treated: | Was worker hospitalized as an inpatient? ☐ Yes ☐ No — If yes, name hospital:

Next appointment date: | Est. length of further treatment: | Current diagnosis per ICD-9-CM codes:

b

Has the injury or illness caused permanent impairment? ☐ Yes ☐ No ☐ Impairment expected ☐ Unknown

Medically stationary? ☐ Yes (date): ☐ No (anticipated date): (Attach findings of impairment, if any.)

Work ability status:
☐ Regular work authorized start (date):
☐ Modified work authorized from (date): through (date, if known):
☐ No work authorized from (date): through (date, if known):

c

Chart notes: Attach chart notes to this form. The notes should specifically describe: symptoms; objective findings; type of treatment; lab/x-ray results (if any); impairment findings (if any, and note whether temporary or permanent); physical limitations (if any); palliative care plan (specify rendering provider, modalities, frequency, and duration); if referred to another physician, give the name and address; surgery; and history (if closing report).

Provider's name, degree, address, and phone: *(print, type, or use stamp)*

X _____ ***Provider's signature*** _____ ***Date***

—Original and one copy to insurer
—Retain copy for your records
—Copies (include Form 3283) to worker immediately if initial claim, new or omitted medical condition claim, aggravation claim, or change of attending physician or nurse practitioner

827

Notice to worker

Claim acceptance or denial

In most instances, you will receive written notice from your employer's insurer of the acceptance or denial of your claim within 60 days. If your employer is self-insured, your employer or the company your employer has hired to process its workers' compensation claims will send the notice to you. If the insurer or self-insured employer denies your claim, it will explain the reason for the denial and your rights.

Medical care

The health care provider must tell you if there are any limits to the medical services he or she may provide to you under the Oregon workers' compensation system.

If your claim is accepted, the insurer or self-insured employer will pay medical bills due to medical conditions the insurer accepts in writing, including reimbursement for prescription medications, transportation, meals, lodging, and other expenses up to a maximum established rate. You must make a written request for reimbursement and attach copies of receipts. Medical bills are not paid before claim acceptance. Bills are not paid if your claim is denied, with some exceptions. Contact the insurer if you have questions about who will pay your medical bills.

Payments for time lost from work

In order for you to receive payments for time lost from work, your health care provider must notify the insurer or self-insured employer of your inability to work. After the original injury, you will not be paid for the first three calendar days you are unable to work unless you are totally disabled for at least 14 consecutive calendar days or you are admitted to a hospital as an inpatient within 14 days of the first onset of total disability.

You will receive a compensation check every two weeks during your recovery period as long as your health care provider verifies your inability to work. These checks will continue until you return to work or it is determined further treatment is not expected to improve your condition. Your time-loss benefits will be two-thirds of your gross weekly wage at the time of injury up to a maximum set by Oregon law.

Authorization to release medical records

By signing this form, you authorize health care providers and other custodians of claim records to release relevant records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization.

Caution against making false statements

Any person who knowingly makes any false statement or representation for the purpose of obtaining any benefit or payment commits a Class A misdemeanor under ORS 656.990(1).

Palliative care

Palliative care is care that makes you feel better, but does not cure you of an unwanted condition. You must be in the workforce, or in a vocational program, to be allowed to have palliative care.

The following are **not** palliative care:

- Prescriptions, prosthetics, braces, and doctors' appointments to monitor them
- Diagnostic services
- Life-preserving treatments
- Curative care to stabilize an acute waxing and waning of symptoms
- Services to a permanently and totally disabled worker

If you have questions about your claim that are not resolved by your employer or insurer, you may contact:

(Si Ud. tiene alguna pregunta acerca de su reclamación que no haya sido resuelta por su empleador o compañía aseguradora, puede ponerse en contacto con):

Workers Compensation Division
(División de Compensación para Trabajadores)
P.O. Box 14480, Salem, OR 97309-0405
Salem: 503-947-7585
Toll-free: 800-452-0288

Ombudsman for Injured Workers
(Ombudsman para Trabajadores Lastimados)
350 Winter Street NE, Salem, OR 97301-3878
Salem: 503-378-3351
Toll-free: 800-927-1271

OREGON DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Workers' Compensation Division

A Guide for Workers Recently Hurt on the Job

How do I file a claim?

- Notify your employer and a health care provider **of your choice** about your job-related injury or illness as soon as possible. Your employer cannot choose your health care provider for you.
- Ask your employer the name of its workers' compensation insurer.
- Complete **Form 801, "Report of Job Injury or Illness,"** available from your employer and **Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims,"** available from your health care provider.

How do I get medical treatment?

- You may receive medical treatment from the health care provider **of your choice**, including:
  - Authorized nurse practitioners
  - Chiropractic physicians
  - Medical doctors
  - Naturopathic physicians
  - Oral surgeons
  - Osteopathic doctors
  - Physician assistants
  - Podiatric physicians
  - Other health care providers
- The insurance company may enroll you in a managed care organization at any time. If it does, you will receive more information about your medical treatment options.

Are there limitations to my medical treatment?

- **Health care providers may be *limited* in how long they may treat you and whether they may authorize payments for time off work.** Check with your health care provider about any limitations that may apply.
- **If your claim is denied, you may have to pay for your medical treatment.**

If I can't work, will I receive payments for lost wages?

- You may be unable to work due to your job-related injury or illness. In order for you to receive payments for time off work, your health care provider must send written authorization to the insurer.
- Generally, you will not be paid for the first three calendar days for time off work.
- You may be paid for lost wages for the first three calendar days if you are off work for 14 consecutive days or hospitalized overnight.
- If your claim is denied within the first 14 days, you will not be paid for any lost wages.
- Keep your employer informed about what is going on and cooperate with efforts to return you to a modified- or light-duty job.

What if I have questions about my claim?

- The insurance company or your employer should be able to answer your questions.
- If you have questions, concerns, or complaints, you may also call any of the numbers below:

Ombudsman for Injured Workers:
An advocate for injured workers
Toll-free: 800-927-1271
E-mail: oiw.questions@state.or.us

Workers' Compensation Compliance Section
Toll-free: 800-452-0288
E-mail: workcomp.questions@state.or.us

Do I have to provide my Social Security number on Forms 801 and 827? What will it be used for? You do not need to have an SSN to get workers' compensation benefits. If you have an SSN, and don't provide it, the Workers' Compensation Division (WCD) of the Department of Consumer and Business Services will get it from your employer, the workers' compensation insurer, or other sources. WCD may use your SSN for: quality assessment, correct identification and processing of claims, compliance, research, injured worker program administration, matching data with other state agencies to measure WCD program effectiveness, injury prevention activities, and to provide to federal agencies in the Medicare program for their use as required by federal law. The following laws authorize WCD to get your SSN: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).

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