# 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.



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

	WCD employer no.:
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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.		
	Wor	Vorker's legal name, street address, and mailing address:			Language preference: Male/fe		Male/femal	nale Social Security no. (see Form 3283):			Occ.		
er					Claim no. (if known):			Date/time of original injury:			Nature		
Worker or provider				Chain no. (ii known).				Zate, and of original injury.					
lo.				Date of bi	of birth: Occupation:		pation:	Last d		Last date worked:	Part		
УГр	Phone:												
er (	Emp	oloyer at time of original injury — na	Health insurance company name and p				ne:	Event					
ork					Workers' compensation insurer's name, address:								
×													
	Pho	ne:		Assoc. object									
		orker: Check reason for filing	this form, answer o	questions	(if any), a	ind si	ign below						
		First report of injury or disease (Do not complete or sign if you do not intend to make a claim.)  Check here if you have more than one job									ob. $\square$		
	Have you injured the same body part before? Yes No				If yes, when:			escribe accid	_				
	П	Request for acceptance of a ne	ew or omitted medica	l condition	n on an exis	sting	claim						
e	Condition:												
논	$\Box$	<u> </u>											
Worker	Ш	Notice of change of attending p	physician or nurse pr	ractitioner	•								
<b>\$</b>	Reason for change:    Deposit of aggregation of opinional injury (cotton) wavesning of underlying condition)												
	Report of aggravation of original injury (actual worsening of underlying condition)												
	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 belief. (See back of form.)				t of my know	vledge	anu	Vorker's signature		<del></del> -	Date		
		ovider: If worker initiated this	s report give worker	r a conv i	mmediatel	lv		0					
		the worker filed this report for:	report, give wormer	woopy						To get the	name and		
	• First report of injury or illness – Send this form to the workers' compensation insurer within 72 hours of visit.  To get the name address of the in												
	• New or omitted medical condition – Attach chart notes, including diagnostic codes. Send this form to the insurer within call the Workers'									orkers'			
											mpensation Division's		
											er index 7-7814, or visit		
		the date of first treatment. Che	eck the following, if appl	icable:	I request in	surer	to send its	records.	_	online:			
	Aggravation of original injury – Sign this form and send it to insurer within five days of visit.  WorkCompCover												
	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.									300 0 11 1021.			
	Date/time of first treatment: Last date treated: Was worker hospitalized as an impatient? Ves No.												
eľ					If yes, name hospital:								
Provider	a	Next appointment date: Est. length of further treatment: Current diagnosis per ICD						M codes:					
2		Has the injury or illness caused perma	Medically Yes (date): (Attach findings of										
		Yes No Impairme		stationary?					nent, if any.)				
	b		egular work authorized st	art (date):									
		]	from (date):				through (date, if known): through (date, if known):						
			o work authorized from (							•	1. (10. )		
	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)  —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										007		
	<u>X</u>							attending physician or nurse					
	Provider's signature Date							practitioner					

## 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

440-827 (1/12/DCBS/WCD/WEB)



## 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 jobrelated 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).