ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

Employer's FEIN	Date of Report	Case of File #	Is this a lost workday case?
Employer's Name		Doing business as	
Employer's mailing address			
Nature of business or service		SIC code	
Name of Worker's Compensation carrier/admin	Policy / contract #		Self-insured
Employee's full name	Home Phone #	Social security #	Birthdate
Employee's mailing address			Employee's email address
		# Dependents	Employee's average weekly wage
Job title or occupation	Department		Date hired
Time employee began work	Date and time of accident		Last day employee worked
If the employee died as a result of the accident, give date of death		Did the accident occur on the employer's permise	
Address of accident			
What was the employee doing when the accident occurred?			
How did the accident occur?			
What was the injury or illness? List the body affected and explain how it was affected			
What object or substance, if any, directly harmed the employee?			
Name and address of physician/healthcare professional			
If treatment was given away from the worksite, list the name and address of place it was given			
Was the employee treated in an emergency room?		Was the employee hospitalized overnight as a patient?	
Reported by:	Signature	Title and telephone #	

Please send this form to: ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE ROAD SPRINGFIELD, IL 62703-5118. By law, employers must keep accurate records of all work related injuries or illness (except for certail minor injuries). Employers shall report to the Commission all injuries resulting in the liss of more then scheduled workdays. Filling this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any sense. This information is confidential. IC45 6/09

Employee Report

Name: ID: Claim Number:

Date / Time of Accident: /

Date Reported:

Where did the Accident occur?

Reason for being in the area?

How did the accident occur?

Who else saw the accident?

To whom did you report this accident to?

Body part and how it was affected:

Have you received medical treatment?

Treatment was performed at the following location:

I agree the above is true and accurate

Employee's Signature: ____________________ Date: ____________

Supervisor Report

This WILL be setup as a claim
and assigned to adjuster

Employee Name: ID: Claim Number:

Date / Time of Accident: /

Date Reported:

Loss Causation: Lost time from work:

Accident Location: Injury

Treatment performed outside of workplace?

What object of substance, if any, directly harmed the employee?

Body part:

Did the accident occur on the employer's permise?

Supervisor Report

This WILL be setup as a claim
and assigned to adjuster

Employee Name: ID: Claim Number:

Date / Time of Accident: /

Date Reported:

What was the employee doing at the time of the accident?

What were the environmental condtions at the accident site?

What was the sequences of the events that led up to the accident? What materials, equipment and tools were involved?

What was done immediately after the accident?

What unsafe conditions or actions contributed to the accident?

What system design and implementation problems contributed to the accident?

What actions will be taken to reduce unsafe conditions and actions?

What actions will be taken to strengthen system design and implementaion

Created by: Last Modified by:

Created Date: Date Last Modified:

I agree the above is true and accurate

Supervisor's Signature: ______________________ Date: ______________

Witness Report

Employee Name: ID: Claim Number:

Date / Time of Accident: /

Date Reported:

Witness: Type of Witness:

What was the employee doing at the time of the accident?

What was the sequences of the events that led up to the accident? What materials, equipment and tools were involved?

What was done immediately after the accident?

What were the environmental condtions at the accident site?

What materials, equipment and tools were involved?

I agree the above is true and accurate

Witness's Signature: ______________________ Date: ______________

Error: Subreport could not be shown.

Workers' Compensation Benefit Ticket

THE USE OF THIS TICKET IS LIMITED TO THE TREATMENT WHICH IS MEDICALLY RELATED TO THE INJURY REFERENCED BELOW.

MEDICAL CLAIM INFORMATION

Administrator:
IPMG
Claims Management Services
225 Smith Road
St. Charles, IL 60174

FIRST FILL TICKET

Insured

Injured Employee

Claim Number

Policy Number

Date of Loss/Injury

Body Part

PHARMACY CLAIMS BILLING

OPTUMRx

BIN: 610011
PCN: IRX
RxGrp: IPMGCMS
Cardholder ID = Claimants SSN

Workers Comp Date of Injury is Required

***** FOR ALL CLAIMS PROCESSING QUESTIONS PLEASE CONTACT**

PHARMACY HELP DESK AT (800) 880-1188 ***

**** PHARMACIST Please ask for SSN and Date of Injury ****

**** IF PRIOR AUTHORIZATION IS REQUIRED CALL (877) 616-0504**

OR FAX TO (888) 587-4929 **

BILLING INSTRUCTIONS

Submit Bills to:

C/o IPMG Claims Management Services

225 Smith Road — Phone: (877) 616-0504

St. Charles, IL 60174 — Fax: (888) 587-4929

*Submit Bills Electronically using Payer ID: IPMWC
Questions please contact Smart Data 855-650-6590 (www.sdata.us)*

PHYSICIAN INFORMATION

CALL (877) 616-0504 FOR AUTHORIZATION / NOTIFICATION ON THE FOLLOWING:

- Discharge Planning
- Outpatient Surgery
- Durable Medical Equipment
- Potential Catastrophic Loss
- Epidural Steroid Injections
- Physician Referrals
- Home Health Care
- Second Surgical Opinion
- Hospitalization
- Skilled Nursing Facility
- IV Therapy
- Therapy (OT/PT/ST)
- Outpatient Diagnostic Testing (MRI, CT Scan Review, Ultrasound)

**** Doctors and Employees ****

**** Please Contact Your Claims Representative To Discuss Transitional Duty Opportunities ****

****This Benefit Ticket is not an approval to provide treatment and is provided only to expedite the approval process and assure that there are no unnecessary delays in treatment for a work-related injury. You must call the above number and obtain approval for all services.****

WAGE STATEMENT

Employer:

First full date of disibility: ____________________

Employee:

Date of Hire:

The employee is paid:

_______ Weekly

_______ Every 2 weeks

_______ Twice a month

Current Hourly Rate: ____________________

Is Overtime:

_______ Mandatory

_______ Voluntary

Number of hours employee is normally scheduled to work each week:

	Dates Incl. of Each Week Pd		Hrs Wkd	Reg Pay	OT Pay		Dates Incl. of Each Week Pd		Hrs Wkd	Reg Pay	OT Pay
	From (mm/dd/yy)	To (mm/dd/yy)					From (mm/dd/yy)	To (mm/dd/yy)			
1.						27.					
2.						28.					
3.						29.					
4.						30.					
5.						31.					
6.						32.					
7.						33.					
8.						34.					
9.						35.					
10.						36.					
11.						37.					
12.						38.					
13.						39.					
14.						40.					
15.						41.					
16.						42.					
17.						43.					
18.						44.					
19.						45.					
20.						46.					
21.						47.					
22.						48.					
232 3.						49.					
24.						50.					
25.						51.					
26.						52.					
SUBTOTAL weeks 1-26						SUBTOTAL weeks 27-52					
						GRAND TOTAL					

This is a correct statement of Employee's earnings as actually taken from our Payroll Records.

Employer's Signature: ______________________________

Title: ______________________________