ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

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<th>Employer's FEIN</th>
<th>Date of Report</th>
<th>Case of File #</th>
<th>Is this a lost workday case?</th>
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<tr>
<td>Employer's Name</td>
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<td>Employer's mailing address</td>
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<td>Nature of business or service</td>
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<td>Name of Worker's Compensation carrier/admin</td>
<td>Policy / contract #</td>
<td>Self-insured</td>
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<td>Employee's full name</td>
<td>Home Phone #</td>
<td>Social security #</td>
<td>Birthdate</td>
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<td>Employee's mailing address</td>
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<td># Dependents</td>
<td>Employee's email address</td>
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<td>Job title or occupation</td>
<td>Department</td>
<td>Date hired</td>
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<tr>
<td>Time employee began work</td>
<td>Date and time of accident</td>
<td>Last day employee worked</td>
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<td>If the employee died as a result of the accident, give date of death</td>
<td>Did the accident occur on the employer's premises</td>
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<td>Address of accident</td>
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</table>

- 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 certain minor injuries). Employers shall report to the Commission all injuries resulting in the loss 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 ID: 
Name: 
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?
What was the employee doing at the time of the accident?

What were the environmental conditions 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 implementation?

I agree the above is true and accurate

Supervisor's Signature: ____________________ Date: _______________
What was the employee doing at the time of the accident?

What were 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 conditions 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

PHARMACY CLAIMS BILLING

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

FIRST FILL TICKET

Insured
Injured Employee
Claim Number
Policy Number
Date of Loss/Injury
Body Part

PHYSICIAN INFORMATION

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

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

PHARMACY CLAIMS BILLING

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
St. Charles, IL 60174
Phone: (877) 616-0504
Fax: (888) 587-4929

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

** 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:**

**Employee:**

First full date of disability: ____________________________

Date of Hire: ____________________________

The employee is paid: Weekly

Current Hourly Rate: ____________________________

Every 2 weeks

Is Overtime: Mandatory

Twice a month Voluntary

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

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<th>Dates Incl. of Each Week Pd</th>
<th>Hrs Wkd</th>
<th>Reg Pay</th>
<th>OT Pay</th>
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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: ____________________________