Weill Cornell Medicine

EMPLOYEE ACCIDENT / INCIDENT REPORT

EMPLOYEE

1. DATE OF ACCIDENT	2. TIME OF ACCIDENT	3. DATE OF REPORT	4. SHIFT ☐ Day ☐ Eve ☐ Night	5. #DAYS WORKED/WK	6. HOURS/DAY	7. Time Shift Started ☐ AM ☐ PM	8. ☐ FULL TIME ☐ PART TIME ☐ OTHER

9. EMPLOYEE NAME	10. HOME PHONE	11. Work Phone:	12. SSN	13. DATE OF HIRE

14. EMPLOYEE HOME ADDRESS (NUMBER, STREET, APT #, CITY, ZIP)	15. Employee ID	16. GENDER: ☐ Male ☐ Female	17. DATE OF BIRTH

18. DEPARTMENT	19. WORK LOCATION	20. JOB TITLE	21. Post Graduate Year	22. AFFILIATION ☐ 1199 ☐ NYSNA ☐ NON-UNION 23. ☐ OTHER

24. EXACT LOCATON WHERE ACCIDENT OCCURRED (BUILDING, FLOOR, ROOM)	25. NATURE OF INJURY OR ILLNESS AND PART OF BODY AFFECTED	26. ACCIDENT OCCURRED ON PREMISIS? ☐ Yes ☐ No

27. DESCRIBE IN FULL DETAIL HOW ACCIDENT OCCURRED: WHAT HAPPENEND, WHAT WERE YOU DOING WHEN INJURED, INCLUDED OBJECTS, SUBSTANCES AND EQUIPMENT INVOLVED

28. WERE THERE ANY WITNESSES ☐ No ☐ Yes ***LIST FULL NAME, DEPARTMENT AND PHONE NUMBER***

29. Supervisor Name:	30. Supervisor phone and/or email:

31. AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize any licensed physician, medical practitioner, nurse, pharmacist, hospital, clinic or other medically-related facility, insurance or reinsurance company, consumer reporting agency, employer or former employer or others who have any information as to the diagnosis, treatment or prognosis of any physical or mental condition of mine, including any alcohol or drug abuse information and any information regarding my occupation or salary, to give any and all such information to RMPG, its employees, agents, reinsurer and legal representatives to which I may submit a claim. I agree that at photographic copy of this authorization shall be as valid as the original. I understand that the information obtained by this authorization will be used by RMPG to determine eligibility for insurance benefits. Any information obtained will not be released to any person or organization except to other persons or organizations performing a business or legal service in connection with my claim or as may be otherwise permitted or required by law.

32. EMPLOYEE SIGNATURE	DATE

MEDICAL

33. DATE OF TREATMENT	34. TIME ☐ AM ☐ PM	35. MEDICAL CARE PROVIDED AT: ☐ WH&S ☐ ED ☐ Treatment Declined ☐ OTHER : _____

36. NATURE OF TREATMENT ☐ NONE ☐ FIRST AID ONLY ☐ MEDICAL TREATMENT

38. FOLLOW UP: ☐ NOT REQUIRED
☐ RETURN TO WH&S ON
☐ REFERRED TO:_____

DATE:_____

37. DISPOSITION:
☐ RETURN TO REGULAR DUTIES, DATE_____
☐ UNABLE TO RETURN TO WORK FOR AT LEAST_____WORK DAYS BEYOND DAY OF ACCIDENT
☐ RETURN TO RESTRICTED DUTIES (EXPLAIN):

39. DIAGNOSIS:

40. NAME OF HEALTH CARE PROVIDER (PRINT)	SIGNATURE/CODE	DATE

INVESTIGATION

41. Further investigation required? ☐ Yes ☐ No

If Yes, document a summary of the investigation (if applicable, include root cause and preventative measures implemented):

NAME (PRINT)	DEPARTMENT	e-mail	DATE	WORK EXT.

Weill Cornell Medicine

Workers' Compensation

Workers' Compensation provides lost pay protection and medical expense reimbursement for any absence from work due to an on-the-job injury or occupational illness. **Employees must apply by submitting an incident report and be approved for Workers' Compensation by Gallagher Bassett**, **Weill Cornell Medicine's third-party plan administrator**.

Medical Only: Gallagher Bassett will send you paperwork that will include all your claim information, including the claim number and how to submit expenses **within one week of receiving your incident report.**

Medical and Loss Time: You may be eligible for Workers' Compensation pay **if you lose more than five days of work for your work-related injury.**

- **Request a leave**, contact HRSC@med.cornell.edu and HRLeaveAdminTeam@med.cornell.edu
- You must provide a doctor's note supporting your time off within one week of your incident.
- **Gallagher Bassett will reach out to you on the phone number you provided on the incident report to confirm details and create your case number within one week of receiving your information.**
- Family Medical Leave (FMLA) will run concurrently with loss time over five days.

Pharmacy RX: If you need **emergency medication** while your workers' compensation claim is pending, CadenceRX will provide your first fill. A temporary ID card is provided on the second page of this document. CadenceRX can be reached at 888-813-0023.

Returning to Work: Prior to returning to work, your medical provider must provide a return-to-work date to both the WCM Leave Administration Team and your Department.

- You are required to provide a physician's statement regarding your fitness for performing job duties.
- If restrictions and/or limitations are listed by your provider, contact EmployeeRelations@med.cornell.edu in advance to coordinate your return to work
- In some cases, a medical examination at Occupational Health Services may be required at no expense to the employee.

Medical Bills: Please send any medical bills received along with your Workers' Compensation claim number to Gallagher Bassett for processing:

Gallagher Bassett
Carrier Code: W376008
Address: PO Box 2934, Clinton, IA 52733-2934
Fax: 315-453-5597

Gallagher Bassett Contacts (for assistance after receiving your WC claim number)

Claims Assistant Joyce Lovelace	**Phone** 585-641-2562	**Email** Joyce_Lovelace@gbtpa.com
Team Lead Chad Wainman	**Phone** 315-741-3921	**Email** Chad_Wainman1@gbtpa.com
Sr. Resolution Manager Shari Huggins	**Phone** 315-741-3110	**Email** Sharon_Huggins@gbtpa.com

WORKERS' COMPENSATION PRESCRIPTION INFORMATION

Employer: Weill Cornell Medicine

Please fill out the employee information below and provide the employee with this document to take to any pharmacy for their Workers' Compensation prescriptions.

Employee:

Gallagher Bassett has partnered with **Cadence Rx** to make filling workers' compensation prescriptions easy. Medications may be subject to formulary and pre-authorization requirements.

This document serves as a temporary prescription card. A permanent prescription card specific to your work-related injury or illness will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. Cadence Rx has a network of over 72,000 pharmacies nationwide. To locate a network pharmacy near you, please use the pharmacy locator at http://cadencerx.com/find-a-pharmacy/ or call Cadence Rx toll-free at 1-888-813-0023.

IF YOU HAVE QUESTIONS OR NEED ASSISTANCE AT THE PHARMACY, PLEASE CALL 888-813-0023

Pharmacist:

Please obtain the below information from the injured employee if not already filled in by the employer to process prescriptions for the workers' compensation injury only.

For questions or rejections, please call 1-888-813-0023. Please do not send the patient home or have the patient pay for medication(s) before calling Cadence Rx for assistance.

Note: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

Prescription Drug ID Card

Employee Name:	
Member ID Number*	***Refer to Member ID Format**
Date of Injury:	
Group Number:	**VXRQZY**
PCN Number:	**CRX**
BIN Number:	**021460**

Card Created On: _____/____/____

Pharmacy Information

This form allows you to fill your initial prescriptions with a maximum cost of $300 per medication and no more than a 14-day supply per prescription. Pharmacy, if you need assistance processing this claim, please call 1-888-813-0023.

The pharmacy benefit card is only to be used for medications prescribed for your work-related injury. By using this card, you acknowledge and accept financial responsibility for any prescriptions billed under this card that are later found to be unrelated to your injury.

- **Member ID format: The ID must start with FF followed by the last 4 digits of the social security number plus 8-digit DOI (MMDDYYYY). Example: FF999901012018**