West Virginia Workers' Compensation Employees' and Physician's Report of Occupational Injury or Disease

For BrickStreet Use Only
Claim Number:
Team Assigned:

SECTION I - EMPLOYEE'S CLAIM INFORMATION

1. Name: Last	First		MI
2. Address:			3. Telephone: - -
City:	State:	Zip:	4. Social Security Number:
5. Date of Birth:	6. Sex: ☐ M ☐ F		7. Marital Status:
8. Date of Injury or Last Exposure: Time: ☐ a.m. ☐ p.m.			9. Time you Began Work on Date of Injury: ☐ a.m. ☐ p.m.
10. Date you Stopped Working Due to Injury:			
11. Have you Retired? ☐ Yes ☐ No	If "yes," what was the date you retired?		
12. Employer's Name:		Supervisor's Name:	
Address:			
City:	State:	Zip:	Telephone: - -
13. Job Title / Description:			
14. Body Parts Injured:			
15. Describe How Your Injury Occurred (Specify the cause, what you were doing, and equipment / objects involved):			
16. Did Injury Occur on Employer's Property? ☐ Yes ☐ No Address where Injury Occurred:			
17. Please Identify Any Witnesses to Your Injury:			

I certify that the above is true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I hereby authorize any physician, chiropractor, surgeon, practitioner or other healthcare provider, any hospital, including Veterans' Administration or governmental hospital, and medical service organization, any insurance company, any law enforcement or military agency, any government benefit agency including the Social Security Administration, or any other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to the diagnosis, treatment and/or counseling for HIV/AIDS, psychological conditions, and/or alcohol or substance abuse, for which I must give specific authorization. A Photostat of this authorization shall be valid as the original.

Employee's Signature: Date: / /

SECTION II – ALL INFORMATION MUST BE COMPLETED BY INITIAL PROVIDER

1. Name of Physician / Hospital:		2. FEIN / Social Security Number:	
3. Address:			
City:	State:	Zip:	Telephone: - -
4. Date of Initial Treatment:		5. Date Patient May Return to Work:	
6. Have you advised the patient to remain off work 4 or more days? ☐ Yes If yes, indicate dates: from to ☐ No If no, is the patient capable of ☐ Full Duty ☐ Modified Duty If the patient is capable of returning to modified duty, specify any limitations/restrictions:			
7. Condition is a direct result of: ☐ Occupational Injury? ☐ Occupational Disease? ☐ Non-Occupational Condition?			
8. Did this injury aggravate a prior injury / disease? ☐ Yes ☐ No If yes, explain:			
9. Description of injury or occupational disease:			
10. Body Part(s) Injured:		11. ICD10-CM Diagnosis Code(s) in order of severity:	
12. Name of Physician Referred to:		13. If the patient was hospitalized, where?	

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge I have been informed of my responsibilities under West Virginia Workers' Compensation Law and agree to abide by such in the administration of services provided thereunder. I understand the submission of false statements or billing may result in prosecution under state and federal law. I further agree to release any office notes/test results immediately to the employer or their representative.

Physician's Signature: Date: / /

General Instructions for Completing the BI-1,
"West Virginia Workers' Compensation Employees' and Physician's Report of Occupational Injury or Disease"

Please Read Carefully

BI-1, West Virginia Workers' Compensation Employees' and Physician's Report of Occupational Injury or Disease: To be completed by the claimant and the medical provider.

This form should not be used to file occupational pneumoconiosis or hearing loss claims.

To the Claimant: Section I of this form must be completed by you. When you have completed this form, make a copy for your records and give a copy to your employer. The initial medical provider is responsible for completing Section II of this form. If you do not receive a decision on your claim within 14 days after submitting the form, contact BrickStreet Insurance. To be eligible for benefits, a claim must be filed with BrickStreet Insurance within six months from and after the injury or death. If you have any questions, you may contact BrickStreet at 1-866-452-7425 or visit our Web site at www.brickstreet.com.

To the Initial Medical Provider: Section II of this form must be completed by you. The timely provision of information regarding the claimant's condition is vital in deciding eligibility for benefits. Each answer should be as specific as possible. You should immediately send a copy of all records, office notes and test results regarding the claimant's exam to BrickStreet Insurance. Please forward the original completed form to BrickStreet Insurance and provide a copy to the claimant. If you have any questions, you may contact BrickStreet Insurance at 1-866-452-7425 or visit our Web site at www.brickstreet.com.

Special Instructions for Section I	
Question 8	This date is defined as either the date you were injured or the date you were last exposed if you are filing an occupational disease claim.
Question 13	Provide your specific job title and describe the duties of the job you are currently working.
Question 15	Please provide as much detail as possible and attach additional pages if space is needed.

Special Instructions for Section II	
Questions 1, 2	The group and FEIN are required by BrickStreet for billing purposes.
Question 8	Describe in detail what effect, if any, the claimant's previous health may have on this injury.

Please attach additional pages if space is needed and include any appropriate reports.

Return completed form to: BrickStreet Mutual Insurance
P. O. Box 3151
Charleston, WV 25332-3151

When completing this form, enclose attachments if additional space is needed.