

# APPENDIX C



## WEST VIRGINIA WORKERS' COMPENSATION EMPLOYEES' AND PHYSICIAN'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

For Encova use only
Claim number:
Team assigned:

SECTION I - EMPLOYEE'S CLAIM INFORMATION

1. Last name	First name	MI
2. Address		3. Telephone
City	State	ZIP
4. Social Security number	4. Social Security number	
5. Date of birth	6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Marital status
8. Date of injury or last exposure	Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	9. Time you began work on date of injury
10. Date you stopped working due to injury		<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
11. Have you retired? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Address where injury occurred		
17. Please identify any witnesses to your injury		
<p>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 health care 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.</p>		
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 four or more days? <input type="checkbox"/> Yes If yes, indicate dates from _____ to _____ <input type="checkbox"/> No If no, is the patient capable of <input type="checkbox"/> Full duty <input type="checkbox"/> Modified duty If the patient is capable of returning to modified duty, specify any limitations/restrictions	
7. Condition is a direct result of <input type="checkbox"/> Occupational injury? <input type="checkbox"/> Occupational disease? <input type="checkbox"/> Non-occupational condition?	
8. Did this injury aggravate a prior injury/disease? <input type="checkbox"/> Yes <input type="checkbox"/> 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?
<p>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.</p>	
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 Encova Insurance. To be eligible for benefits, **a claim must be filed with Encova within six months** from and after the injury or death. If you have any questions, contact Encova at 866-452-7425 or visit our website at [encova.com](http://encova.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 Encova. **Please forward the original completed form to Encova and provide a copy to the claimant.** If you have any questions, contact Encova at 866-452-7425 or visit our website at [encova.com](http://encova.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	
Question 1, 2	The group and FEIN are required by Encova 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

**Encova Insurance**  
**P.O. Box 3151**  
**Charleston, WV 25332-3151**

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