RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

For assistance call 1-800-342-1741
or contact your local EAO Office
Report all deaths within 24 hours 1-800-219-8953 or (850) 922-8953

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last)	Social Security Number	Date of Accident (Month-Day-Year)	Time of Accident □ AM □ PM

HOME ADDRESS

Street/Apt #: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)

OCCUPATION	INJURY/ILLNESS THAT OCCURRED	PART OF BODY AFFECTED

DATE OF BIRTH

_____ / _____ / _____

SEX

□ M □ F

EMPLOYER INFORMATION

COMPANY

NAME: **Nova Southeastern University**

D. B. A.: **Same**

Street: **3301 College Avenue**

City: **Ft Lauderdale** State: Florida Zip: **33314**

FEDERAL I.D. NUMBER (FEIN)

59-1083502

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

Education

POLICY/MEMBER NUMBER

2499309

TELEPHONE Area Code Number

DATE EMPLOYED

_____ / _____ / _____

PAID FOR DATE OF INJURY

□ YES □ NO

EMPLOYER'S LOCATION ADDRESS (If different)

Street: _____

City: _____ State: _____ Zip: _____

LOCATION # (If applicable) _____

LAST DATE EMPLOYEE WORKED

_____ / _____ / _____

RETURNED TO WORK □YES □ NO

IF YES, GIVE DATE

_____ / _____ / _____

WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? □ YES

LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP

_____ / _____ / _____

PLACE OF ACCIDENT (Street, City, State, Zip)

Street: _____

City: _____ State: _____ Zip: _____

COUNTY OF ACCIDENT _____

DATE OF DEATH (If applicable)

_____ / _____ / _____

AGREE WITH DESCRIPTION OF ACCIDENT?

□ YES □ NO

RATE OF PAY □ HR □ WK

$ _____ PER □ DAY □ MO

Number of hours per day _____
Number of hours per week _____
Number of days per week _____

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234. Section 440.105(7), F.S. **I have reviewed, understand and acknowledge the above statement.**

_____ _____
EMPLOYEE SIGNATURE (If available to sign) DATE

_____ _____
EMPLOYER SIGNATURE DATE

NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL

AUTHORIZED BY EMPLOYER □ YES □ NO

CLAIMS-HANDLING ENTITY INFORMATION

□ 1 (a) Denied Case - DWC-12, Notice of Denial Attached
□ 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached

□ 2. Medical Only which became Lost Time Case (Complete all required information in #3)
Employee's 8TH Day of Disability _____ / _____ / _____

Entity's Knowledge of 8TH Day of Disability _____ /_____ / _____

□ 3. Lost Time Case - 1st day of disability _____ / _____ / _____ Full Salary in lieu of comp? YES Full Salary End Date _____/ _____ / _____

Date First Payment Mailed _____ / _____ / _____ AWW _____ Comp Rate _____

□ T.T. □ T.T. - 80% □ T.P. □ I.B. □ P.T. □ DEATH □ SETTLEMENT ONLY

Penalty Amount Paid in 1st Payment $_____ Interest Amount Paid in 1st Payment $_____

REMARKS:

INSURER CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE
SERVICE CO/TPA CODE #	**CLAIMS-HANDLING ENTITY** FILE #	

INSURER NAME

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE
Cannon Cochran Management Services, Inc.
PO Box 948399 | Maitland| FL 32794-8399
866-291-0194 | 407-660-5600 | Fax: 217-477-6946
FICURMAmail@ccmsi.com

DWC-1 Purpose and Use Statement

The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.

NSU | NOVA SOUTHEASTERN UNIVERSITY
Florida

NSU EMPLOYEE STATEMENT REGARDING CAUSE OF ACCIDENT AND REQUEST FOR MEDICAL TREATMENT

Employee Name: _____ SSN: _____

Date of Birth _____ Date of Injury: _____

Job Title: _____ Supervisor's Name_____

Telephone contact Information: _____ Supervisor's Signature: _____

Dept. /Center: _____ Supervisor's telephone #: _____

Employee Refused Medical Care at time of Injury □Yes □No

List activity prior to accident (work related activity only):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

WORKERS' COMPENSATION TREATMENT AUTHORIZATION FORM

This is a Worker's Compensation Treatment Authorization Form. This Form is not a guarantee of eligibility or compensability for Workers' Compensation Benefits.

To be completed by employer (please print)

Account Number: F45

Employer Name:____Nova Southeastern University_____

Employer Address:__3301 College Avenue, Ft. Lauderdale, Florida 33314_____

Employee Name:_____

Social Security Number:_____Date of Injury:_____

Type of Injury:_____

Body Part Injured:_____

Supervisor issuing form:__Charmaine Beckford | (T) 954-262-5404 | Email: bcharmai@nova.edu

Supervisors: Please give this completed form to the injured employee to take with them to the physician.

This form is for one time use, only on this date _____.

Providers: You must call Cannon Cochran Management Services, Inc. toll free at 1-866-291-0194 prior to any additional treatment/admission or referral, other than an emergency. In an emergency, notification to CCMSI is required within 24 hours.

Send Medical Bills To:

Cannon Cochran Management Services, Inc.
PO Box 948399 | Maitland| FL 32794-8399
1-866-291-0194 | 407-660-5600 | Fax: 217-477-6946 | FICURMAmail@ccmsi.com

FICURMA
Workers' Compensation Prescription Information

Employer:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

	FICURMA CCMSI
Employee Name:	
Group#:	P2KA
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	003858
Day supply is limited to 14 days for a new injury.	
myMatrixx Help Desk: (877) 804-4900	

Employee:

FICURMA has partnered with ***myMatrixx*** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury 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. myMatrixx has a network of over 64,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist:

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

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

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

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900

AUTHORIZATION FOR MEDICAL RECORDS AND COMMUNICATION RELEASE

Name:_____ Date of Birth:_____ Social Security #:_____

I hereby authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of my mental or physical health, history, condition or wellbeing, to supply such information to my employer or its insurance carrier, claims administrator or attorneys.

I specifically authorize any treating physician or medical care provider to communicate orally or in writing with my employer or its insurance company, claims administrator, rehabilitation or medical management consultant or attorneys as to my care and treatment, and as to any other issues including diagnosis, prognosis, causal connection of care and treatment to my work injury or duties, and ability to work. I hereby waive my physician-patient privilege. In conjunction with this, I also authorize any treating physician or medical provider to review any additional materials provided to them.

A photocopy of this authorization shall be as valid as the original. This release shall remain valid for the length of my claim.

Note: Workers' Compensation Requests Are Exempt From HIPAA. Pursuant to 45 CFR, Sect. 164.512(1) a covered entity may without penalty under HIPAA disclose protected health information to the extent necessary to comply with the law relating to workers' compensation.

_____
NAME-PLEASE PRINT

_____
SIGNATURE

_____
DATE

Cannon Cochran Management Services, Inc.
PO Box 948399 | Maitland| FL 32794-8399
866-291-0194 | 407-660-5600 | Fax: 217-477-6946 | FICURMAmail@ccmsi.com

False and Fraudulent Claim Warning

Please read the following information carefully. This form must be signed and returned within 30 days of the date it was received, stating that you have reviewed, understand and acknowledge the statement of benefits and/or payments shall be suspended until such signature obtained.

Workers' Compensation fraud includes but is not limited to the following:

- Requesting and/or receiving temporary total, temporary partial, permanent total disability or impairment benefits while working for gain as an employee of a business, independent contractor, yourself or a business and not reporting that income to the insurance company.
- Making a false or written statement and/or submitting false documents to your employer, your physician and/or the insurance company or their representatives for the purpose of filing or supporting a claim for workers' compensation benefits.
- Misrepresenting facts concerning an industrial accident, injury or illness to your employer, your physician and/or the insurance company or their representatives.
- Failing to report earnings when requested to do so by the insurance company.
- Selling your personal information to third parties for use of misrepresenting facts to any medical provider or insurance company.

Florida

Any person who knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud punishable as provided in Florida Statute 817.234.

I have reviewed, understand and acknowledge the above. This information is true and correct to the best of my knowledge.
Workers Name:

_____

Please type or print

Claim #:_____Employee: _____

Employer: _____

Employees' Address: _____

Phone: _____

Workers' Signature:_____Date: _____

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Florida

Workers' Compensation Witness Report Form (To be completed by witness only)

Name of injured employee: _____

Name of witness: _____

Telephone # of Witness_____

Location where the incident occurred: _____

Date of incident: _____ Time of incident: _____

1. What were you (the witness) doing at the time of the incident?
   _____
2. How and when did you become aware of the incident?
   _____
3. What did you hear at the time of the incident?
   _____
4. Describe what you saw at the time of the incident:
   _____
5. Who else was present?
   _____
6. Please relate any additional information you have pertaining to the incident:
   _____
   _____
   _____

Witness's signature: _____ Date signed: _____

Cannon Cochran Management Services, Inc.
PO Box 948399 | Maitland| FL 32794-8399
866-291-0194 | 407-660-5600 | Fax: 217-477-6946 | FICURMAmail@ccmsi.com

Please fax or email the completed form to the adjuster for handling. Thank you.

REQUEST FOR MILEAGE REIMBURSEMENT

NAME:	
EMPLOYER:	Nova Southeastern University
CLAIM NUMBER:	
CLAIMANT ADDRESS:	
WORK ADDRESS:	
DATE OF INJURY:	**ADJUSTERS:** Terri Krepps

Date of Visit	Name of Medical Facility (Including Pharmacies) with address	Roundtrip Miles	Residence or Work (Please indicate)

Total Miles: _____ x ____0.444_____ = $ _____

I hereby certify or affirm that the above mileage was incurred by me as necessary traveling expenses related to those medical facility visits pursuant to my workers' compensation case.

_____ _____

Signature **Date**