

Workers' Compensation Division (WCD)

Report of Occupational Injury

Prior to Completing this Form you must
Read the instructions on the Back of this Form

For Division Use Only

Claim Number: _____

Team Assigned: _____

WC-123 Rev. 1/98

Section I: Injured Worker Section - All Information Must Be Completed:

<p>1. Name: Last _____ First _____ M _____</p> <p>2. Social Security Number : _____ - _____ - _____</p> <p>3. Injury / Last Exposure Date: ____/____/____ Time: ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM</p> <p>4. Address: _____ City: _____ State: _____ Zip Code: _____ County: _____</p> <p>5. Telephone: (____) _____ - _____ <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>6. Date of Birth: ____/____/____ Marital Status: _____</p> <p>7. Time You Began Work on Date of Injury: ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM</p> <p>8. Stopped Work for Injury: Date ____/____/____ Time ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM</p> <p>9. Date Employer Was Notified of Injury: ____/____/____</p> <p>10. Who Was Notified of Injury: _____ Phone: (____) _____ - _____</p> <p>11. Date First Went to Doctor / Hospital for this Injury: ____/____/____</p> <p>12. Name of Doctor / Hospital: _____</p>	<p>13. How Did Injury Occur? (Specify the cause, what you were doing, and equipment/objects involved.): _____ _____ _____</p> <p>14. Job Title / Description: _____</p> <p>15. Did Injury Occur on Employer's Property? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Where? _____</p> <p>16. Employer Name and Address: _____ _____</p> <p>17. Supervisor's Name: _____ Phone: (____) _____ - _____</p> <p>18. List Name(s) and Phone Number of Witness(es) to the Accident (Attach List for More): Name: _____ Phone #: (____) _____ - _____</p> <p>19. List the Name and Phone Number for any other employers for whom you are currently working? (Attach List for More) _____</p> <p>20. If you have had any previous accidents or conditions affecting the same body part, give dates and details. (Attach List for More): _____</p>
--	---

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge and belief. I am aware the law, specifically W. Va. Code §23-4-19 provides for severe penalties if I knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase benefits to which I am not entitled. By signing this application, I authorize the Division and designated agents to examine all hospital and medical records and have verbal discussions with physicians, on any medical information pertaining to this injury and or any condition for which I have previously received medical attention. I acknowledge the provisions of W. Va. Code §23-4-7 providing authorization for release of medical information by a physician to my employer or employer representative. Signature: _____ Date: ____/____/____

Section II: Attending Physician Section - All Information Must Be Completed:

<p>1. WCD Vendor Number: _____</p> <p>2. FEIN or SSN: _____</p> <p>3. Name of Physician / Hospital: _____</p> <p>4. Address: _____ City: _____ State: _____ Zip Code: _____</p> <p>5. Phone: (____) _____ - _____</p> <p>6. Date You Were First Consulted For This Condition: ____/____/____</p> <p>7. Is Condition a Result of (Check One) Occupational Injury? <input type="checkbox"/> Occupational Disease?: <input type="checkbox"/> Nonoccupational Condition?: <input type="checkbox"/></p> <p>8. Nature, Body Part and Type of Injury (e.g. Sprained back due to over exertion): _____ _____</p> <p>9. Diagnosis Code(s) (ICD9-CM) in Order of Severity: _____ _____</p> <p>10. Date claimant stopped work due to this condition: ____/____/____</p>	<p>11. Did this injury aggravate a chronic or prior injury/disease?: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Explain: _____ _____</p> <p>12. Disability Period: <input type="checkbox"/> Less than 4 days <input type="checkbox"/> 2 Weeks <input type="checkbox"/> Over 4 Weeks <input type="checkbox"/> 1 Week <input type="checkbox"/> 3 Weeks</p> <p>13. Date Claimant Was (Will Be) Able to Return to Work: ____/____/____</p> <p>14. Will claimant need Physical or Vocational Rehabilitation Services?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unkn</p> <p>15. Describe rehabilitation needs: _____ _____</p> <p>16. Can Claimant return to modified work? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what restrictions?: _____ _____</p> <p>17. If claimant was hospitalized, where?: _____</p> <p>18. Name and Address of Physician Referred to: _____</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 or withhold a material fact or statement respecting any information requested by the Division. By signing this form, I acknowledge the provisions of W. Va. Code §23-4-19 which provides for severe criminal penalties for the knowing and with fraudulent intent to aid and abet anyone in securing or attempting to secure benefits to which he or she is not entitled. Also, by signing this form, I acknowledge that any office notes / test results should be immediately sent to the Division.

Signature: _____ Date: ____/____/____

Section III: Employer Section - All Information Must Be Completed:

• Employer sign here as acknowledgment of receipt of Sections I and II: _____ Date: _____

<p>1. WCD Policy Number: _____</p> <p>2. Industrial Code: _____ Occupation (DOT) Code: _____</p> <p>3. FEIN or SSN: _____ Phone: (____) _____ - _____</p> <p>4. Name of Employer as Listed with WCD: _____</p> <p>5. Address to Send Claim Related Mail: _____ City: _____ State: _____ Zip Code: _____</p> <p>6. TPA Name & Phone, if applicable: _____</p> <p>7. Employee is: <input type="checkbox"/> Owner/Part Owner <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Officer <input type="checkbox"/> Volunteer</p> <p>8. If owner/part owner/officer, are wages included on wage reports?: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Date employee was first employed by you: ____/____/____</p> <p>10. Time at present job: _____ Years _____ Months</p>	<p>11. Date Claimant Returned to Work: ____/____/____</p> <p>12. If returned to work, is it alternate or modified work? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, indicate wages: Hourly rate: _____ Hours per week: _____</p> <p>13. Daily rate of pay on the date of injury? \$ _____</p> <p>14. If part-time, Hourly rate: _____ Hours per week (25 or less): _____</p> <p>15. Did injury occur at address listed in question 5?: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Where? _____ _____ State: _____, County: _____, Zip Code: _____</p> <p>16. Do you disagree with any information provided above, or do you have any reason to question this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, You must attach a specific explanation to this form.</p> <p>17. Was an incident report completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No</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 or withhold a material fact or statement respecting any information requested by the Commissioner. By signing this form or by having an agent sign it on my behalf, I acknowledge the provisions of W. Va. Code §23-4-19 which provides for severe criminal penalties for the knowing and with fraudulent intent to aid and abet anyone in securing or attempting to secure benefits to which he or she is not entitled. Also by signing this form I acknowledge that any incident report will be attached to the back of this form.

Signature: _____ Date: ____/____/____

**Please Read Carefully - General Instructions for Completing
WC-123 Form "Report of Occupational Injury"**

General Overview: The Report of Occupational Injury, form WC-123, is divided into three sections:

Section I: To be completed by the injured worker	Section II: To be completed by the attending physician	Section III: To be completed by employer
---	---	---

A claim cannot be established until the Workers' Compensation Division has received the "Report of Occupational Injury." This form should not be used to file occupational pneumoconiosis or hearing loss claims. Please note that W. Va. Code §23-4-1 provides that employees of the state and its political subdivisions are ineligible to receive workers' compensation while drawing sick leave benefits at the same time for the same reason. It is the joint responsibility of the claimant and the employer to file an Election of Options form with the WC-123.

To the Injured Worker: Section I on this form must be completed by you. Your attending physician is responsible for completing the second section. After both sections are completed the gold copy of this form is yours to keep. Your doctor is expected to complete and submit their completed portion of the form to you. Once you receive the doctor's completed section you must take the form to your employer so that they can complete the third section. Your employer is required to send the completed form to the Division. If you do not receive a decision on your claim within 14 days after the form is given to your employer, you should check with your employer to see if they have completed their section. If the employer has not completed their section you can send in the completed claimant and physician sections to address listed below. We will begin processing your claim and will contact your employer for completion of the third section. The ultimate responsibility of filing a claim rests with you. To be eligible for benefits, **an application for benefits must be filed with the Division within six months** from and after the injury or death. If you have any questions, you may contact the Division at 1-800-628-4265.

Question number	Explanation
3	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
13	Your description of how the injury occurred is reviewed to determine eligibility for benefits.
14	This field is used to describe the job you are currently working. If you are a state, municipal, or county employee you need to write that in this field. For example, Construction worker for the state.

To the Attending Physician: Section II of this form must be completed by you. The timely provision of information regarding the injured worker'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/test results regarding the injured worker's exam to the Division. Your office is responsible for sending the original form to the claimant.

Question number	Explanation
1	You can locate this number on your Remittance Advice Statement from WCD. If you are not registered as a provider with the WCD, please contact our Provider Registration Unit at 1-800-998-4644.
2	The Federal Identification number or Social Security number you report to the WCD for billing purposes.
3	Under what name, facility, or group do you report to the WCD?
7	In your opinion, was the patient injured at work, exposed to a disease at work, or is the condition not work-related?
10	If patient did not stop work, please complete this field as follows: 0/00/00.
11	Describe in detail what affect, if any, the patient's previous health may have on this injury.
14	Indicate whether or not the claimant will need rehabilitation services. If unknown, check the Unkn box.

To the Employer: Section III of this form is required to be completed and submitted by you within five (5) days of receipt of the claimant's report of injury. This information is used to assign the liability of this claim.

Question number	Explanation
1	WCD Policy Number indicated on your WCD wage reports
2	Reference the "Dictionary of Occupational Titles" and complete the form with the code that best describes the employee's job title
4	Name as listed with WCD
5	Where should letters regarding individual claims be directed
6	List the Third Party Administrator (TPA) that will be involved in this claim, if any
7	An employee is considered part time if the employee works 25 or less hours per week
13	Enter the employee's daily rate of pay on the date of injury.
17	Any incident reports may be requested by the Division.

Please mail the completed form to: **Workers' Compensation Division
P.O. Box 431
Charleston, WV 25322-0431**

All parties completing this form may enclose attachments if additional space is needed.