OREGON DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Workers' Compensation Division

Worker's and Physician's Report for Workers' Compensation Claim Form 827

NOTES to physician or nurse practitioner

➔ **Ask the worker to complete this form ONLY in the following circumstances:**

- **First report of injury or disease**
- **Report of aggravation of original injury**
- **Notice of change of attending physician or nurse practitioner**

Give the worker a copy immediately. You must file Form 827 with the workers' compensation insurer if the worker has indicated any of the above reasons for filing in the Worker's Section of the 827.

➔ **The worker should NOT complete this form for the following:**

- **Progress report**
- **Closing report**
- **Palliative care request**

For these reports, you have the *option* of filing Form 827, submitting chart notes, or submitting a report that includes data gathered on Form 827.

➔ **If the worker completes and signs this form, give the worker a copy immediately.**

➔ **When you file Form 827 as required (or by election) you can simplify your filing by attaching thorough chart notes. Simply check the box(es) next to your filing reason(s) and the box in Section C, affirming that chart notes are attached, and complete the signature block.**

If you have questions about completion of Form 827, contact a benefit consultant:	If you don't know the name and address of the insurer, call the Workers' Compensation Division Employer Index:
(800) 452-0288	(503) 947-7814 or find it at: www4.cbs.state.or.us/ex/wcd/cov/search/index.cfm

To order supplies of this form, call (503) 947-7627. This form may also be downloaded from WCD's Web site, www.wcd.oregon.gov/policy/bulletins/formsbyno.html, in MS Word 2000 or PDF format.

Notice to Worker and Physician or Nurse Practitioner

Do not use Form 827 as "notice of change of attending physician or nurse practitioner," **unless** the new medical service provider will be **primarily responsible** for the treatment of the injured worker due to a compensable occupational injury or disease.

Being "primarily responsible" for the treatment does *not* include:

- Treatment on an emergency basis
- Treatment on an "on-call" basis
- Consulting
- Specialist care
- Exams done at the request of the insurer or Workers' Compensation Division.
- Exams done as "worker requested medical examinations" under ORS 656.325 (compensability).

Do NOT use Form 827 for the above circumstances.

Incorrect use of this form may result in *delay of benefits* to the worker.

DEPARTMENT OF CONSUMER & BUSINESS SERVICES — *Workers' Compensation Division*

Worker's and Physician's Report for Workers' Compensation Claims

OPTIONAL: WCD employer no.: | Policy no.:

Note to Physician or Nurse Practitioner: **Ask the worker to complete this form ONLY for the three filing reasons in the worker's section; do not have the worker complete or sign form if this is a progress report or palliative-care request.**

Dept. Use: Ins. no. | Occ. | Nature | Part | Event | Source | Assoc. object

Worker or physician

Worker's legal name, street address, and mailing address:

Phone:

Worker's language preference: ☐ English ☐ Spanish ☐ Russian ☐ Vietnamese ☐ Other (please specify):

Claim no. (if known):

Social Security no. (see back of form):

Date of birth:

Male/female ☐ ☐

Date/time of original injury:

Employer at time of original injury — name and street address:

Phone:

Occupation:

Last date worked:

Workers' compensation insurer's name, address:

Worker

Worker: Check reason for filing this form, answer questions (if any), and sign below.

☐ **First report of injury or disease** (Do not complete or sign if you do not intend to make a claim.)
Has the same body part been injured before? ☐ Yes ☐ No (If yes, describe when and how.)
By my signature I authorize the use of my SSN as described in paragraph 2 on the back. If you do not authorize use of your SSN as described in paragraph 2 on back, check here ☐.

☐ **Report of aggravation of original injury**

☐ **Notice of change of attending physician or nurse practitioner**

Reason for change:

By my signature I am giving **NOTICE OF CLAIM or CHANGING MY ATTENDING PHYSICIAN OR NURSE PRACTITIONER**. I authorize medical providers and other custodians of claim records to release relevant medical records. I certify that the above information is true to the best of my knowledge and belief . (See #s 3 and 4 on back.)

Check here if you have more than one employer. ☐

Describe accident:

X

Worker's signature **Date**

Physician

Physician: If worker initiated this report, give worker a copy immediately.

☐ **First report of injury or disease** (Mail this form to the workers' compensation insurer within 72 hours of visit.)

☐ **Change of attending physician or nurse practitioner** (I accept responsibility for the care and treatment of the above named worker.)
☐ Prior medical records have been requested from the previous attending physician or nurse practitioner.
☐ **Insurer is hereby requested to send its records.**

☐ **Progress report** ***OR*** ☐ **Closing report** (See instructions in Bulletin 239.)

☐ **Aggravation; actual worsening of underlying condition** (Mail 827 signed by attending physician to insurer within five days of visit.)

☐ **Palliative care request** — Complete remainder of form, except Section b. (Worker must be currently employed or in vocational training to be eligible.) Attach a palliative care plan or describe in "NOTES" below. See back of form.

If you don't know the name and address of the insurer, call the Workers' Compensation Division's Employer Index (503) 947-7814, or visit on-line:
www4.cbs.state.or.us/ex/wcd/cov/search/index.cfm
To order supplies of this form, call (503) 947-7627.

a

Date/time of first treatment: | Last date treated: | Hospitalized as inpatient? ☐ Yes ☐ No If yes, name hospital:

Next appointment date: | Est. length of further treatment: | Current diagnosis per ICD-9-CM code(s):

b

Has the injury or illness caused permanent impairment? ☐ Yes ☐ No ☐ Impairment expected ☐ Unknown

Medically stationary? ☐ Yes (date): ☐ No (anticipated date): (Attach findings of impairment, if any.)

Work ability status:
☐ Regular work authorized start (date):
☐ Modified work authorized from (date): through (date, if known):
☐ No work authorized from (date): through (date, if known):

c

NOTES: Describe the following ***or*** check if chart notes are attached. ☐
(Chart notes should *specifically* describe items below.)

Symptoms:
Objective findings:
Type of treatment:
Lab/X-Ray results (if any):
Impairment findings (if any):
☐ Temporary ☐ Permanent
Physical limitations (if any):
Palliative care plan/justification:
If referred to another physician give name/address:
Surgery:
History (if closing report):
Remarks:

Health insurance provider name and phone: *(print or type)*

Physician's or nurse practitioner's name, degree, address, and phone: *(print, type, or use stamp)*

X

Physician's or nurse practitioner's signature *Date*

This form replaces and satisfies reporting requirements for Forms 827, 828, 829, 2215, and 2837. See Bulletin 292.

— Original and one copy to insurer
— Retain copy for your records
— Copy to worker immediately if initial claim, aggravation claim, or change of physician

827

Notice to worker

Important information about your social security number (SSN)

1. You must provide your SSN. The Workers' Compensation Division (WCD) of the Department of Consumer and Business Services (DCBS) has authority to request your SSN under the Privacy Act of 1974, 5 USC & 552a (West 1977), Section 7(a)(2)(B). Authority under state law is provided in Oregon Revised Statutes 656.254 and 656.265. Your SSN will be used by DCBS to carry out its duties under ORS Chapter 656, which include compliance, research, claims processing, and injured-worker program administration. The workers' compensation insurer will use your SSN to obtain records related to your claim.
2. If you are filing this 827 form as a "First report of injury or disease," your authorization for the use of your SSN is also requested for use by various government agencies to carry out their statutory duties, including, but not limited to, planning, research, child support enforcement, employment assistance, benefit coordination, child labor law enforcement, risk management, hazard identification, rate setting, and training programs. If you do not authorize this use, please check the box on the front of this form under "First report of injury or disease." Checking this box will not interfere with the processing of your workers' compensation claim.

Authorization to release medical records

3. By signing this 827, you are authorizing medical providers and other custodians of claim records to release records related to the injury or disease claimed on this 827 per ORS 656 and OAR 436. Medical information relevant to the claim includes a past history of the complaints of, or treatment of, a condition similar to that presented in the claim or other conditions related to the same body part.

Caution against making false statements

4. Any person who knowingly makes any false statement or representation for the purpose of obtaining any benefit or payment is punishable, upon conviction, by imprisonment for a term of not more than one year or by a fine of not more than $1,000, or by both per ORS 656.990(1).

If you have questions about your claim that are not resolved by your employer or insurer, you may contact:

(Si Ud. tiene alguna pregunta acerca de su reclamación que no haya sido resuelta por su empleador o compañía aseguradora, puede ponerse en contacto con):

Workers' Compensation Division
(División de Compensación para Trabajadores)
P.O. Box 14480, Salem, OR 97309-0405
Call Salem: (503) 947-7585 or (503) 947-7993 TTY
Toll-free in Oregon: 1-800-452-0288

OR

Ombudsman for Injured Workers
(Ombudsman para Trabajadores Lastimados)
350 Winter Street NE, Salem, OR 97301-3878
(503) 378-3351 or (503) 947-7189 TTY
or toll-free, 1-800-927-1271

Notice to worker and physician or nurse practitioner

Aggravation is the actual worsening of a condition resulting from the original injury. Form 827 must be signed by the attending physician and sent to the insurer within five days of visit.

A medical service provider who can be *primarily responsible* for the treatment of an injured worker may either be a doctor, physician, or an authorized nurse practitioner.

Primarily responsible medical service provider does not mean a person who provides emergency-room treatment, "on-call" treatment, a consultation or second opinion; specialist care; exams done at the request of the insurer or Workers' Compensation Division; or exams done as "worker-requested medical examinations" under ORS 656.325 (compensability).

Palliative care is a medical service that may reduce or moderate temporarily the intensity of an otherwise stable (medically stationary) condition. The physician must attach a palliative care plan, which must include the name of the provider who will render the care, modalities ordered, frequency, and duration **(not to exceed 180 days)**; and a description of how the requested care relates to the compensable condition, how it will enable the worker to continue current employment or vocational training, and any possible adverse effects on the worker if the requested care is not approved. The insurer has **30 days** to respond in writing to the request. With the approval of the insurer, palliative care is compensable if it is necessary to enable the worker to continue current employment or a vocational training program. If the insurer does not approve, the medical service provider or the worker may request approval from the director of the Department of Consumer and Business Services; such request must be made within **90 days** of the insurer's disapproval, or within **120 days** of the date the request was first submitted to the insurer if the insurer did not respond within **30 days**. Palliative treatment may begin prior to insurer approval; however, if the requested care is ultimately disapproved, insurer payment for such treatment may be disallowed. The following types of medical care are NOT palliative care and ARE compensable after the worker is medically stationary, without the insurer's prior approval: services provided to a permanently and totally disabled worker; administration and monitoring of prescription medications; services necessary to provide or monitor prosthetic devices, braces, and supports; services provided under an aggravation claim (ORS 656.273); services provided for claims reopened under the board's own motion (ORS 656.278); diagnostic services; life-preserving treatments; and curative care to stabilize a temporary and acute waxing and waning of symptoms of the accepted conditions.

Regular work means the job the worker held at the time of injury.

Notice to worker
(continued)

Claim acceptance or denial

You will receive written notice from your employer's insurer of the acceptance or denial of your claim. If your employer is self-insured, the notice will be sent by your employer or the company your employer has hired to process its workers' compensation claims. If your claim is denied, the reason for the denial and your rights will be explained.

Medical care

You must tell your doctor or hospital on your first visit that your injury or illness is work-related. The doctor must tell you if there are any limits to the medical services he or she may provide to you under the Oregon workers' compensation system.

If your claim is accepted, the insurer or self-insured employer will pay medical bills due to medical conditions the insurer accepts in writing, including reimbursement for prescription medications, transportation, meals, lodging, and other expenses, up to a maximum established rate. Your request for reimbursement must be made in writing and accompanied by copies of receipts. Medical bills are not paid before claim acceptance. Bills are not paid if your claim is denied, with some exceptions. Contact the insurer if you have questions about who will pay your medical bills.

Payments for time lost from work

In order for you to receive payments for time lost from work, your attending physician must notify the insurer or self-insured employer of your inability to work. After the original injury, you will not be paid for the first three calendar days you are unable to work unless you are totally disabled for at least 14 consecutive calendar days or you are admitted to a hospital as an inpatient within 14 days of the first onset of total disability.

You will receive a compensation check every two weeks during your recovery period as long as your attending physician verifies your inability to work. These checks will continue until you return to work or it is determined further treatment is not expected to improve your condition. Your time-loss benefits will be two-thirds of your gross weekly wage at the time of injury up to a maximum set by Oregon law.

440-827 (12/05/DCBS/WCD/WEB)