How To Process Your Workers' Compensation Insurance Claim

The following are steps needed to insure your claim is processed in a timely manner:

1. Immediately report your injury to your supervisor and request Injury Packet from HR or Email a request for a packet to workerscompensation@tulaliptribes-nsn.gov
2. Employees must comply with the post-accident drug test. Drug tests are performed by CDACD. #360-716-4153 **If immediate medical attention is needed, please seek medical attention first.
3. Seek medical attention.
   IMPORTANT: Tulalip Tribes has a medical management program in effect for employees who are injured at work. Employees that need medical treatment must contact the designated medical facility Everett Concentra at 425-259-0300 to schedule an appointment. ***This is the medical facility designated for employees to seek medical care. Everett Concentra office hours are Monday-Friday 7am-6pm. If you are injured outside of the above noted hours for the Everett Concentra or it is the weekend, you will be referred to seek out medical care with the Concentra in Lynnwood. If you are injured and need emergency medical care, you should seek immediate treatment at the nearest emergency medical facility. In these cases, the claimant must follow-up care with the Everett Concentra, as soon as possible, before returning to work. It is the employees' responsibility to make follow-up appointments during their non-working hours.*
   **Please be advised that treatment with any other provider may not be authorized for payment under your claim.*
4. Have the attending physician completed the Physician's Initial Report included in this packet.
5. Complete the Employee and Injury/Illness section of the Accident report included in this packet. This should be completed within two days of the date of the injury. Return all the completed forms to Email: workerscompensation@tulaliptribes-nsn.gov HR will complete the bottom portion of the accident report and forward to Tribal First.
6. As soon as Tribal First receives your completed Accident Report, your claim will be processed and a claim number assigned. If Tribal First does not receive a completed form, time loss compensation or medical benefits cannot be provided.

If you have any questions regarding, please email workerscompensation@tulaliptribes-nsn.gov or call 360-716-1400. You may also contact Tribal First for additional information toll free at 1-877-777-8039 or email NewClaimsWC@tribalfirst.com.

Workers' Compensation Questions & Answers

Q. Who handles my claim if I am hurt on the job?

A. Tulalip Tribes workers' compensation program is privately insured and is administered by:

Tribal First
1-877-777-8039
Email Us: tribal@tribalfirst.com or
Visit Us: www.TribalFirst.com

The state's workers compensation system does not have jurisdiction. A copy of Tulalip Tribes Workers' Compensation Ordinance is available online:

https://www.codepublishing.com/WA/Tulalip/html/Tulalip09/Tulalip0915.html

Q. If I am unable to work due to my injury, when will compensation begin?

A. If you are off work as a result of your injury, there is a 3 calendar day waiting period in which benefits are not payable, unless 14 consecutive days are missed.

Q. Can I take my personal leave and collect time loss compensation benefits at the same time?

A. If you are off work and elect to take leave, time loss compensation benefits cannot be paid.

TULALIP TRIBES

Central Drug and Alcohol Compliance Department (CDACD)

Where We're Located

NEW LOCATION!

MAIN LINE: **360-716-4153**

ADDRESS: **6332 31st Ave NE Suite C**
Tulalip, WA 98271

HOURS: **Monday–Friday 8:00 AM–4:30 PM**

TDS-24601

Concentra

Puget Sound Locations

1. **Bellevue**
   1925 140th Ave NE
   Bellevue, WA 98005
   Mon-Fri: 8 am - 5 pm
   Ph: 425.865.8060
   Fx: 425.562.1273

2. **Everett - Broadway**
   3726 Broadway, Ste 101
   Everett, WA 98201
   Mon-Fri: 8 am - 5 pm
   Ph: 425.259.0300
   Fx: 425.259.0301

3. **Everett - Paine Field**
   3101 111th St SW, Unit T/U
   Everett, WA 98204
   Mon-Fri: 8 am - 5 pm
   Ph: 425.267.0299
   Fx: 425.513.1446

4. **Federal Way**
   1300 South 320th St, Ste B
   Federal Way, WA 98003
   Mon-Fri: 8 am - 5 pm
   Ph: 253.839.2727
   Fx: 253.839.6081

5. **Kent**
   24031 104th Ave SE
   Kent, WA 98030
   Mon-Fri: 8 am - 5 pm
   Ph: 253.852.1824
   Fx: 253.859.5139

6. **Lacey**
   3928 Pacific Ave SE
   Lacey, WA 98503
   Mon-Fri: 8 am - 5 pm
   Ph: 360.455.1350
   Fx: 360.455.5354

7. **Lynnwood**
   4320 196th St SW, Ste D
   Lynnwood, WA 98036
   Mon-Fri: 8 am - 5 pm
   Sat: 9 am - 5 pm
   Ph: 425.774.8758
   Fx: 425.672.8944

8. **Puyallup**
   3850 South Meridian, Ste 10
   Puyallup, WA 98373
   Mon-Fri: 8 am - 5 pm
   Sat-Sun: 9 am - 5 pm
   Ph: 253.840.1840
   Fx: 253.841.9336

9. **Redmond**
   16690 Redmond Way
   Redmond, WA 98052
   Mon-Fri: 8 am - 5 pm
   Ph: 425.882.0100
   Fx: 425.867.5401

10. **Seattle - Denny**
    140 4th Ave N, Ste 150
    Seattle, WA 98109
    Mon-Fri: 7 am - 4 pm
    Ph: 206.682.7418
    Fx: 206.623.0884

11. **Seattle - First Avenue**
    3223 1st Ave S, Ste C
    Seattle, WA 98134
    Mon-Fri: 6 am - 4:30 pm
    Ph: 206.624.3651
    Fx: 206.624.2391

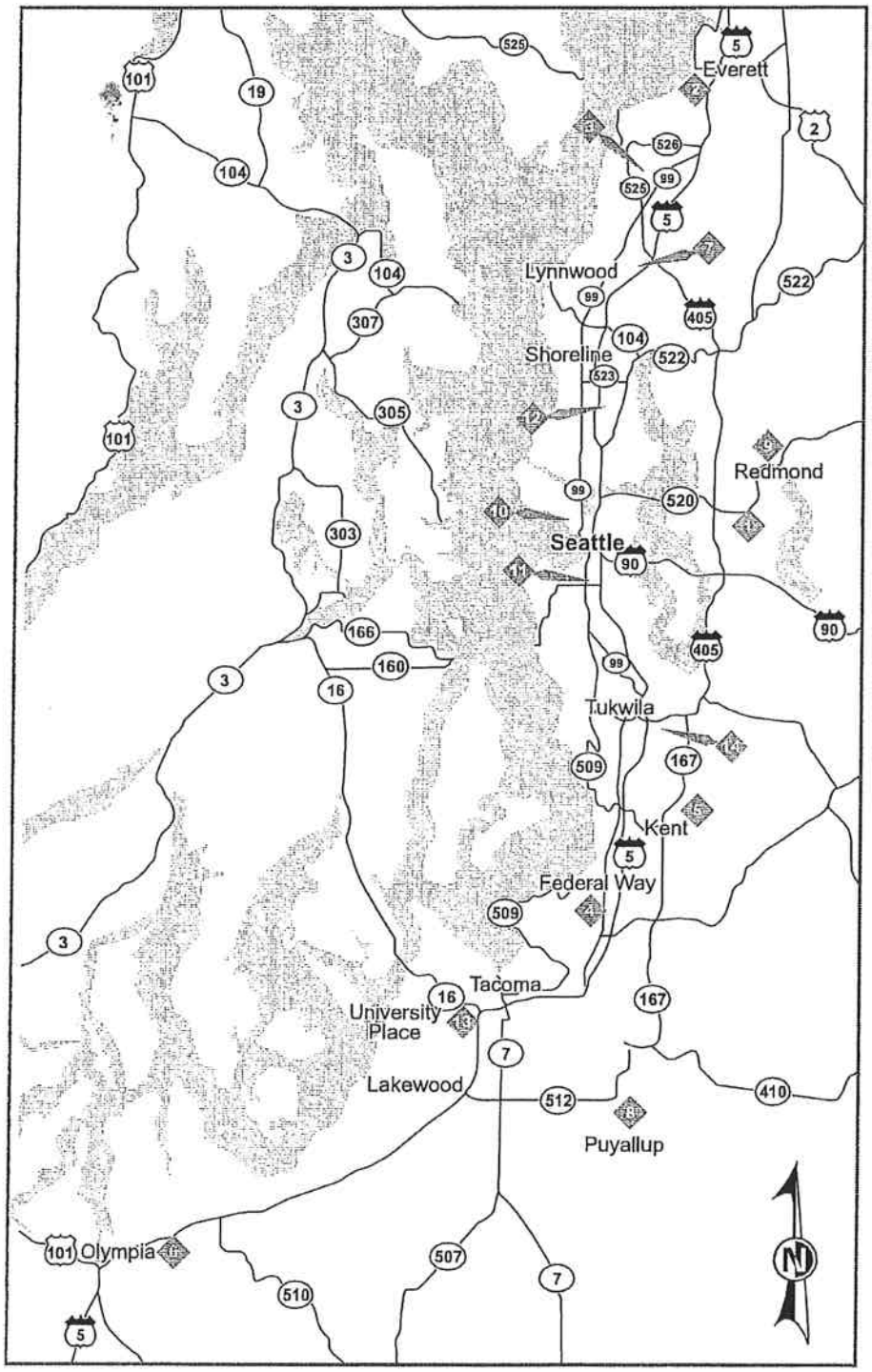
12. **Seattle - Northgate**
    836 NE Northgate Way
    Seattle, WA 98125
    Mon-Fri: 8 am - 5 pm
    Ph: 206.784.0737
    Fx: 206.784.0369

13. **Tacoma**
    2624 South 38th St
    Tacoma, WA 98409
    Mon-Fri: 8 am - 5 pm
    Sat: 9 am - 5 pm
    Ph: 253.475.5908
    Fx: 253.475.5958

14. **Tukwila**
    200 Andover Park E, Ste 8
    Tukwila, WA 98188
    Mon-Fri: 8 am - 5 pm
    Sat: 8 am - 12 pm
    Ph: 206.575.3136
    Fx: 206.575.7657

- Work-related injuries receive immediate triage assessment.
- Pre-placement and DOT exam forms are provided, or you may use other DOT approved MER and/or MEC forms.
- No contract is required when working with Concentra. Our fees are competitive and adhere to the applicable state workers' compensation fee guidelines.
- Visit concentra.com/our-locations for a list of locations and driving directions.

Puget Sound Locations



EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

TRIBAL FIRST
Submit Report to:
newclaimsWC@tribalfirst.com
Fax (360) 413-9291

☐ Fatality

EMPLOYER

1. FIRM NAME: Tulalip Tribes
1A. POLICY NUMBER
2. MAILING ADDRESS (Number and Street, City, State, Zip): 6046 Marine Drive Tulalip, WA 98270
2A. PHONE NUMBER: 360-716-1400
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, State, Zip): Same
3A. LOCATION CODE
4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.

DO NOT USE THIS COLUMN
Case No.
Ownership
Occupation

EMPLOYEE

5. **EMPLOYEE NAME**
6. **SOCIAL SECURITY NUMBER**
7. **DATE OF BIRTH** (mm dd yy) / /
8. **HOME ADDRESS** (Number and Street, City, State, Zip)
8A. **PHONE NUMBER**
8B. **MAILING ADDRESS** (If different from Home Address. Number and Street, City, State, Zip)
9. SEX ☐ MALE ☐ FEMALE
10. **OCCUPATION (Regular job title - NO initials, abbreviations or numbers)**
11. **DATE OF HIRE** / /
12. EMPLOYEE USUALLY WORKS ____ hours per day ____ days per week ____ total weekly hours
12A. EMPLOYMENT STATUS (CHECK APPLICABLE STATUS AT TIME OF INJURY) ◯ regular full time ◯ part-time ◯ temporary ◯ seasonal
12B. DEPARTMENT CODE
13. GROSS WAGES SALARY $ ____ per
13A. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? ☐ YES, $ ____ per ☐ NO
14. Have you ever injured or received treatment to the same body part? ☐ YES ☐ NO
15. Do you have more than one paying job? ☐ YES ☐ NO
15A. Married? ☐ YES ☐ NO
15B. Dependents? ☐ YES ☐ NO

MEDICAL RELEASE AUTHORIZATION: I hereby authorize my physician, hospital, agency, or organization to disclose to my employer or their representatives, any medical records or other information regarding treatment which has previously been furnished to me.
NOTICE: Indian reservations are sovereign nations and are not subject to the state or federal workers' compensation laws. By completion of this form you are submitting to the sole jurisdiction of the tribe. NOTICE: Making or causing to be made any knowingly false or fraudulent statement written or oral, or purposefully withholding material information in order to receive compensation is unlawful and will result in a denial of benefits, penalties, and/or prosecution.

16. **Employee Signature** _____ **Date:** _____

INJURY OR ILLNESS

17. **DATE OF INJURY OR ONSET ILLNESS** (mm dd yy) / /
18. TIME INJURY/ILLNESS OCCURRED A.M. P.M.
19. TIME EMPLOYEE BEGAN WORK A.M. P.M.
20. IF EMPLOYEE DIED, DATE OF DEATH (mm dd yy) / /
21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO
22. **DATE LAST WORKED (mm dd yy)** / /
23. **DATE RETURNED TO WORK (mm dd yy)** / /
24. IF STILL OFF WORK, CHECK THIS BOX ☐
25. PAID FULL WAGES FORTHE DAY OF INJRUY OR LAST DAY WORKED? ☐ YES ☐ NO
26. SALARY BEING CONTINUED? ☐ YES ☐ NO
27. DATE OF EMPLOYER'S KNOWLEDGE/ NOTICE OF INJURY/ILLNESS (mm dd yy) / /
28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm dd yy) / /
29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burn on right arm, tendonitis of left elbow, lead poisoning.
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)
30A. COUNTY
30B. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.
32. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ NO
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.
34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal form, loading boxes onto truck
35. **HOW INJURY/ILLNESS OCCURRED, DESCRIBED SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS.** (e.g., worker stepped back to inspect work and slipped on scrap metal. As he fell, he brushed against fresh weld, and burned right hand.) USE SEPARATE SHEET IF NECESSARY.
36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, Zip)
36A. PHONE NUMBER
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OR HOSPITAL (Number and Street, City, Zip)
37A. PHONE NUMBER

Weekly wage | **County** | **Nature of injury** | **Part of body** | **Source** | **Event** | **Sec. Source** | **Extent of injury**

Employer comments/ concerns

Completed by (type or print)	**Employer Signature**	**Title**	**Date**

FILING THIS REPORT IS NOT AN ADMISSION OF LIABILITY

RETURN TO TRIBAL FIRST | **PHYSICIAN'S INITIAL REPORT**

1. NAME OF EMPLOYER

CITY | STATE | ZIP

NAME OF EMPLOYER'S SERVICE REPRESENTATIVE

Tribal First
PO Box 609015
San Diego, CA 92160

EMPLOYER'S SERVICE REP PHONE: **(877) 777-8039**

EMPLOYER'S SERVICE REP FAX: **(360) 413-9291**

EMPLOYER'S SERVICE REP EMAIL ADDRESS: **newclaimsWC@tribalfirst.com**

PATIENT INFORMATION

2. NAME OF INJURED WORKER: FIRST MIDDLE LAST | 3. WORKER'S TELEPHONE NUMBER

4. MAILING ADDRESS | 5. SOCIAL SECURITY NUMBER

6. CITY | 7. STATE | 8. ZIP | 9. DATE OF BIRTH (MM/DD/YY)

10. INJURY DATE | 11. INJURY TIME | ☐ AM ☐ PM | 12. Have you missed work due to your injury? If so, what dates were you off? From: _____ To: _____

13. SEX | 14A. MARITAL STATUS | 14B. NUMBER OF DEPENDENTS

15. Describe in detail how your injury or exposure occurred:

16. **MEDICAL RELEASE AUTHORIZATION:**
I HEREBY AUTHORIZE MY HEALTH CARE PROVIDER, HOSPITAL, AGENCY OR ORGANIZATION TO DISCLOSE TO MY EMPLOYER OR MY EMPLOYER'S REPRESENTATIVE ANY RELEVANT MEDICAL RECORDS OR OTHERINFORMATION REGARDING TREATMENT PREVIOUSLY FURNISHED TO ME.

Worker's Signature _____ Date: _____

17. NOTICE: Making any knowingly false or fraudulent statement or withholding information is unlawful.

Worker's Signature _____ Date: _____

Attending Health Care Provider- COMPLETE BOXES 18-27

23. Date patient first seen by you for this injury/condition:

a. ICD DX CODES | b. Diagnosis - specify Right/Left

24. Are there objective findings to support this diagnosis
☐No ☐Yes, Specify

25. Referred for Diagnostic Studies
☐No ☐Yes, Specify

26. Treatment Recommendations:

18. a. Has the worker ever been treated for the same or similar condition?
Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐ _____

b. Is there any pre-existing impairment of the injured area?
Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐ _____

c. Are there any conditions that will prevent or retard recovery?
Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐ _____

d. Was the diagnosed condition caused by this injury or exposure on a more probable than not basis?
No ☐ Yes ☐

19. a. Have you released this worker to return to regular work?
No ☐ Yes ☐ effective date of return to work _____

b. Have you released this worker to return to light duty?
No ☐ Yes ☐ effective date of return to work _____

c. What restrictions are placed on light duty return to work?
Lifting _____
Bending _____
Standing _____
Sitting _____
Other _____

d. If not released, how many days off work due to the work injury? _____

27. Referred Healthcare Provider (Patient Referred for Follow-Up)

Facility Name: _____
Physician Name: _____
Specialty: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____

20. Attending Healthcare Provider

Name (print): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____

21. Licensed Healthcare Provider must sign before report is accepted

Signature: _____ Date: _____

22. IRS Account #

DO NOT SEND THIS FORM TO LABOR & INDUSTRIES

Tribal First
PO Box 609015
San Diego, CA 92160
FAX: (360) 413-9291
EM: newclaimsWC@tribalfirst.com

ACTIVITY PRESCRIPTION FORM (APF)

TRIBAL FIRST

General Info

Worker's Name:	Visit Date:	Claim Number:
Health Care Provider's Name (printed):	Date of Injury:	Diagnosis:

Required: Release for work? *Check at least one*

☐ Worker is **released** to the job of injury without restrictions on (date): ___/___/___ *Skip to "Plans" section below.*

☐ Worker **may perform modified duty**, if available, from (date):
___/___/___ to ___/___/___
☐
___/___/___ to ___/___/___

☐ Worker ***is* working** modified duty or limited hours
Please estimate capacities below and provide key objective finding at right.

☐ Worker not released to any work from (date): ___/___/___ to ___/___/___
☐ Prognosis poor for return to work at the job of injury at any date
☐ May need assistance returning to work

Required: Key Objective Finding(s)

Capacities apply 24/7, please estimate capacities below and provide key objective findings at right. Note - these restrictions should be followed outside of work as well as at work

Required: Estimate what the worker can do *Unless released to JOI*

Capacity duration (estimate days): ☐1-10 ☐11-20 ☐21-30 ☐30+ ☐permanent

Worker can: (Related to work injury.) Blank space = Not restricted	Never	Seldom 1-10% 0-1 hour	Occasional 11-33% 1-3 hours	Frequent 34-66% 3-6 hours	Consistent 67-100% Not restricted
Sit					
Stand / Walk					
Climb (ladder / stairs)					
Twist					
Bend / Stoop					
Squat / Kneel					
Crawl					
Reach Left, Right, Both					
Work above shoulders L R B					
Keyboard L R B					
Wrist (flexation/extension) L R B					
Grasp (forceful) L R B					
Fine manipulation L R B					
Operate foot controls L R B					
Vibratory tasks; high impact					
Vibratory tasks; low impact					

Lifting / Pushing	Never	Seldom	Occas.	Frequent	Constant
Example	50 lbs	20 lbs	10 lbs	0 lbs	0 lbs
Lift L R B	___lbs	___lbs	___lbs	___lbs	___lbs
Carry L R B	___lbs	___lbs	___lbs	___lbs	___lbs
Push / Pull L R B	___lbs	___lbs	___lbs	___lbs	___lbs

Other restrictions/Instructions:

Employer Notified of Capacities?
☐Yes ☐No
Modified Duty Available?
☐Yes ☐No
Date Contact: ___/___/___
Name of Contact:_____
Notes:

Note to Claim Manager:

New diagnosis:_____
Opioids prescribed for: ☐Acute pain ☐Chronic pain

Required: Plans

Worker Progress: ☐As expected / better than expected. ☐Slower than expected. *Address in chart notes*

Current Rehab: ☐PT ☐OT ☐Home exercise ☐Other_____

Surgery: ☐Not Indicated ☐Possible ☐Planned

Comments:

☐Next scheduled visit in: _____ days, _____ weeks.
☐Treatment concluded (MMI)
Any permanent partial impairment?
☐Yes ☐No ☐Possibly
If you are qualified, please rate impairment for your patient.
☐Will rate ☐Will refer ☐Request IME
Care transferred to:_____
Consultation needed with:_____
Study pending:_____

Sign

Signature (**Required**): _____ ☐Doctor ☐ARNP ☐PA-C ( )___-___ Phone number Date: ___/___/___

☐Copy of APF given to worker ☐Discussed with worker