Broadspire Workers' Compensation Reporting Form

To report the injury the Department Supervisor must be prepared to answer the questions listed below Before contacting Broadspire at 800-753-6737

Once form is completed you may fax to 800-245-9927 or Email to nol@ choosebroadspire.com

Is this an Emergency Claim: __ Yes __ No
Business Phone: (___) ____________________
Date of Accident (mm/dd/yy): _____

Reported by: ______________
Title: ______________________
Time of Accident (hh:mm am/pm): _____

Request:
Fax Confirmation with Claim # to (405) _____ _____

A. Employer Information

Parent Company Name: Oklahoma State University Department: ____

Address: 106 Whitehurst City: Stillwater State: OK Zip: 74078 County: Payne

Business Phone (405) 744-5449 Fax: (405) 744-8345 E-mail: _____

Location Code: (Division/Dept) __ _____ *(example: AA C1015)* Nature of Business: University

Class Code: (Office/Clerical: OFC or Other: OTH) ____________________

B. Insured Contact Information

Are You the Contact Person: __ Yes __ No

If No, Enter Contact Name: ________________________Title: ____

Contact Phone (___) ___________________ E-mail: ____

C. Loss Location Information

Did Accident Occur on the Insured Premises: __ Yes __ No

If No, Enter Physical Address: ______________________ City: ______________ State: __ Zip: _____ County: _____

D. Employee Information

CWID: ____________ Employee Name: ____________________________ Birthday: ____________ Age: __

Address: _______________________________ City: __________________ State: __ Zip: _____ County: _____

Home Phone: (___) ____ Business Phone: (___) ____ Sex: _ Female _ Male

Number of Dependents: _ Marital Status: _____

Regular Occupation: _____ Regular Department: _____ Class Code: _____

Date of Hire: _____ Hire County: _____ Hire State: __

Employment Status: _ Full Time _ Part Time Pay Type: _ Monthly _ Bi-Weekly

Gross Wages (hourly/monthly): _____ Hours per Day: __ Days per Week: __ Hours per Week: __

Supervisor Name: _____ **Business Phone**: (___) ____

E. Loss Information

Employee Start Time: _____ Date Employer Notified: _____ Questionable Case: _ Yes _ No

Description of Accident: _____

Removed by Ambulance: _ Yes _ No _ Unknown

Any Stitches/Surgery Required: _ Yes _ No _ Unknown

Was a Fatality Involved: _ Yes _ No (If Yes) Provide Date: _____

Describe Injury or Illness: _____

Body Part Injured (Indicate Right or Left): _____

Work Process Injured was doing: _____

Describe Preventable Measures: _____

Direct Cause: _ Auto Accident _ Faulty Machinery _ Someone's Negligence

If other, Describe Cause: _____

Describe Preventable Measures: _____

Safeguards or Safety Equipment Provided: _ Yes _ No _ Unknown

Safeguards or Safety Equipment Utilized: _ Yes _ No _ Unknown

Employee on Restricted Duty: _ Yes _ No _ Unknown

Full Pay for Day of Injury: _ Yes _ No _ Unknown

Any Lost Time: _ Yes _ No _ Undetermined

Last Day Worked: _____ Start Date of Disability: _____ Date Returned to Work: _____

Salary Continued During Disability: _ Yes _ No _ Unknown

F. Medical Information

Initial Treatment (Select Only One): _ No Medical Treatment _ Minor by Employer _ Minor Hosp/Clinic

_ Emergency Care _ Hospitalized 24 hrs _ Future Medical/Lost Time _ Unknown

Physician Information

Name: _____

Address: _____

City: _____ State: __ Zip: _____

Business Phone: (___) ____

Hospital Information

Name: _____

Address: _____

City: _____ State: __ Zip: _____

Business Phone: (___) ____

G. Witness Information

Name: _____

Address: _____

City: _____ State: __ Zip: _____

Phone: (___) ____

Name: _____

Address: _____

City: _____ State: __ Zip: _____

Phone: (___) ____

If you have any questions, please contact: 800-890-8975, ext 221 or 405-395-9085 Fax

Lisa Colbert
Broadspire Services, Inc.
PO Box 10900
Overland Park, KS 66225-0900

Broadspire will give you a Claim Number: Please note below

Claim Number: ____

Supervisor will complete the Name & Claim Number assigned by Broadspire on the Card below.

WORKERS' COMPENSATION

Employee Name:________________________

Claim Number: _________________________

Employer: Oklahoma State University

Please mail all inquires and bills to:

Broadspire Services, Inc. 800-800-7885

PO Box 25104

Lehigh Valley, PA 18002-5104