TO REPORT AN INJURY CALL: 1-800-831-9531
24 HOURS A DAY / 7 DAYS A WEEK

INTAKE INJURY REPORT

EMAIL or FAX FORM TO: IntakeDepartment@FirstMCO.com | 973-257-2282

TYPE OF CLAIM REPORTING	☐ REPORT ONLY	☐ TELEPHONIC CASE MGMT	☐ FIELD CASE MGMT
DATE		**TIME**	☐ **AM** ☐ **PM**
NAME OF COMPANY/EMPLOYER			
NAME OF EMPLOYER CONTACT		**PHONE**	
SITE OF EMPLOYMENT			

INJURED EMPLOYEE

NAME			
PHONE			
ADDRESS			
CITY:	**STATE:**	**ZIP:**	
SOCIAL SECURITY NUMBER		**DATE OF BIRTH**	
OCCUPATION:			
DEPARTMENT:			
EMPLOYMENT STATUS: ☐ **Full-Time** ☐ **Part-Time** ☐ **Per Diem**			
DATE OF HIRE:	**# OF HOURS:**	**SALARY:**	
MARRIED/SINGLE:	**# OF DEPENDENTS:**		
INSURANCE CARRIER:			
DATE OF LOSS:	**DATE REPORTED:**	**TO WHOM:**	
DATE LAST WORKED:	**DATE LAST PAID:**	**DATE RETURN TO WORK:**	

INJURY INFORMATION

DATE OF INJURY	
TIME OF INJURY	☐ **AM** ☐ **PM**
LOCATION OF INJURY	
HOW DID THE INJURY OCCUR	
WERE THERE ANY WITNESS:	
IF YES, NAME(S):	
WERE THERE ANY PRIOR INJURIES:	
WHERE DID THE EMPLOYEE GO FOR IMMEDIATE TREATMENT:	
DATE TREATED:	
TREATMENT INFO:	
IS FOLLOW-UP TREATMENT NEEDED: ☐ **YES** ☐ **NO**	