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

CASE MANAGEMENT SERVICES

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

DATE	**TIME** ☐ AM ☐ PM		
TYPE OF CLAIM REPORTING	☐ Telephonic Case Management ☐ Field Case Management		
EMPLOYER			
PREPARER'S NAME		**TITLE**	
PREPARER'S PHONE		**EMAIL**	
SITE OF EMPLOYMENT			

GENERAL INFORMATION

POLICY NUMBER	
BENEFIT STATE	
DATE OF LOSS	
TIME OF INJURY	☐ AM ☐ PM

EMPLOYER INFORMATION

EMPLOYER					
FEDERAL EMPLOYER IDENTIFICATION					
STATE UI REGISTRATION #					
ADDRESS					
CITY		**STATE**		**ZIP**	
NATURE OF BUSINESS					
CONTACT PERSON / PHONE NUMBER					

FOR PENNSYLVANIA

ARE YOUR WORKERS COMPENSATION PANELS POSTED	☐ YES ☐ NO
ARE YOUR NOTIFICATION FORMS SIGNED	☐ YES ☐ NO

EMPLOYEE INFORMATION

NAME							
PHONE							
ADDRESS							
CITY:		**STATE:**		**ZIP:**			
SOCIAL SECURITY NUMBER		**DATE OF BIRTH**		**AGE**			
GENDER	☐ MALE ☐ FEMALE						
MARITAL STATUS	☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED			**# OF DEPENDENTS**			
OCCUPATION		**DEPARTMENT**					
DATE OF HIRE:	**# OF HOURS:**	**SALARY/WAGES:**					
EMPLOYMENT STATUS	☐ Full-Time ☐ Part-Time ☐ VOLUNTEER ☐ SEASONAL ☐ OTHER						
WAS THE EMPLOYEE PAID FOR THE DAY OF INJURY:	☐ YES ☐ NO						
INSURANCE CARRIER:							
HAS EMPLOYEE RETURNED TO WORK	☐ YES ☐ NO	**IF YES, INDICATE DATE & TIME**					
PAID WHILE INJURED	☐ YES ☐ NO	**RETURNED WAGE**					

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ACCIDENT INFORMATION

DATE OF INJURY				TIME OF INJURY		☐ AM ☐ PM	
ACCIDENT DEPARTMENT							
ACCIDENT ADDRESS							
CITY		STATE		ZIP		COUNTY	
RETURNED WAGE							
HOW DID THE INJURY OCCUR							
LIST ALL EQUIPMENT EMPLOYEE WAS USING AT TIME OF ACCIDENT							
WORK PROCESS EMPLOYEE ENGAGED IN AT TIME OF ACCIDENT							
WERE SAFEGUARDS PROVIDED: ☐ YES ☐ NO		WERE SAFEGUARDS USED: ☐ YES ☐ NO		WAS ACCIDENT ON PREMISES ☐ YES ☐ NO			
TIME SHIFT BEGINS:	☐ AM ☐ PM			TIME REPORTED	☐ AM ☐ PM		
SUPERVISOR				DATE LAST WORKED			
IS THIS A LOST TIME CLAIM	☐ YES ☐ NO			IF YES, DATE DISABILITY BEGAN			
FATAL?	☐ YES ☐ NO			IF YES, DATE OF DEATH			
IF YES, NAME AND ADDRESS OF NEAREST RELATIVE							
DID THE EMPLOYEE COMMIT AN UNSAFE ACT				☐ YES ☐ NO			
NATURE OF INJURY/BODY PART							
OBJECT/SUBSTANCE INVOLVED							
REASON TO DOUBT VALIDITY OF CLAIM				☐ YES ☐ NO			

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WITNESS INFORMATION

WITNESS NAME					
PHONE					
ADDRESS					
CITY:		**STATE:**		**ZIP:**	

MEDICAL PROVIDER INFORMATION

PROVIDER NAME					
PHONE					
ADDRESS					
CITY:		**STATE:**		**ZIP:**	
WAS EMPLOYEE TREATED IN EMERGENCY ROOM	☐ **YES** ☐ **NO**				
WAS EMPLOYEE HOSPITALIZED OVERNIGHT	☐ **YES** ☐ **NO**				

AGENT INFORMATION

NAME	

COMMENTS

Note: Any attachments (medical records, related documents) should be emailed/faxed/sent along with this form.