MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE #

SIC CODE

EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN

POLICY/SELF-INSURED NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX

☐ MALE (M)

☐ FEMALE (F)

☐ UNKNOWN (U)

MARITAL STATUS

☐ UNMARRIED/SINGLE/DIVORCED (U)

☐ MARRIED (M)

☐ SEPARATED (S)

☐ UNKNOWN (K)

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

OF DEPENDENTS

NCCI CLASS CODE

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:

#DAYS WORKED WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT

NO MEDICAL TREATMENT (0) ☐

MINOR: BY EMPLOYER (1) ☐

MINOR CLINIC/HOSP (2) ☐

EMERGENCY CARE (3) ☐

HOSPITALIZED > 24 HRS (4) ☐

FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) ☐

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

SEE BACK FOR INSTRUCTIONS

WORKERS' COMPENSATION - FIRST REPORT OF INJURY EMPLOYER'S INSTRUCTIONS

GENERAL INFORMATION

EMPLOYER (NAME & ADDRESS INCL ZIP) – The name and address of the entity employing or statutorily responsible for the employee.

SIC CODE – The code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

EMPLOYER FEIN – Employer's Federal Employer Identification Number.

CARRIER/ADMINISTRATOR CLAIM NUMBER – Carrier's claim or file number.

REPORT PURPOSE CODE – A code used with Electronic Data Interchange to define the specific purpose of the report. (Original, Cancel, Change, Correction)

JURISDICTION – State in which you are filing the claim (Mississippi).

JURISDICTION CLAIM NUMBER – Number assigned to claim by Mississippi Workers' Compensation Commission (to be completed by MWCC).

INSURED REPORT NUMBER – The number, if any, used by the employer to identify the claim.

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) – The name and address of the employer's facility where the employee was employed at the time of injury, if different from above.

LOCATION #/ PHONE # – The number, if any, assigned by the employer to identify its location where the injury occurred and the phone number.

CARRIER (NAME, ADDRESS & PHONE NO) – The licensed business entity issuing the contract of insurance and assuming financial responsibility for the claim on behalf of the employer.

POLICY PERIOD – The date that the contract/policy under which the claim occurred began and expired.

CHECK IF APPROPRIATE (SELF-INSURANCE) – An indicator that identifies the employer as one who retains the risks arising from their operations and bears the financial responsibility. A jurisdictionally approved or acknowledged employer, group fund, or association assuming financial risk and responsibility for their employee's worker's compensation claims.

CLAIMS ADMINISTRATOR – The business entity providing claim services on behalf of the carrier, or self-insured. The name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

CARRIER FEIN – Carrier's Federal Employer Identification Number.

POLICY/SELF-INSURED NUMBER – The number assigned by the carrier to the insurance contract/policy for the employer; or any similar number assigned to a self-insured employer.

ADMINISTRATOR FEIN – Federal Employer Identification Number of Administrator.

AGENT NAME & CODE NUMBER – The name of the insurance agent and the agent's code number if known. This information should be found in the insurance policy.

EMPLOYEE/WAGE INFORMATION

NAME (LAST, FIRST, MIDDLE) – Employee's legally recognized name.

ADDRESS – The mailing address used by the employee.

PHONE – A telephone number where the employee can be reached.

DATE OF BIRTH – The date the employee was born.

SOCIAL SECURITY NUMBER – A number assigned by the Social Security Administration used to identify the employee.

DATE HIRED – The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.

STATE OF HIRE – State where employee was hired.

SEX – The code which indicates the sex of the employee.

MARITAL STATUS – The code which indicates the marital status of the employee.

OCCUPATION/JOB TITLE – This is the primary occupation of the employee at the time of the accident or exposure.

EMPLOYMENT STATUS – Indicate the employee's work status. The valid choices are: Full-time, Part-Time, Not Employed, On Strike, Disabled, Retired, Unknown, Apprenticeship Full-Time, Apprenticeship Part-Time, Volunteer, Seasonal, or Piece Worker.

NCCI CLASS CODE – A code which corresponds to the primary occupation which the employee was engaged at the time of accident/injury, or injurious exposure. Codes are found in the NCCI BASIC MANUAL FOR WORKERS' COMPENSATION AND EMPLOYERS LIABILITY INSURANCE.

RATE – The reported employee's wage rate at the time of injury.

 # DAYS WORKED/ WEEK – The number of days worked by the employee in a week.

FULL PAY FOR DAY OF INJURY – State whether employee was paid his full wages on the injury date.

DID SALARY CONTINUE – State whether employee's salary was continued by the employer in lieu of compensation benefits.

OCCURRENCE/TREATMENT INFORMATION

TIME EMPLOYEE BEGAN WORK – The time employee began work on date of injury.

DATE OF INJURY/ILLNESS – The date employee was injured.

TIME OF OCCURRENCE – The time employee was injured.

LAST WORK DATE – The date employee last worked following the injury.

DATE EMPLOYER NOTIFIED – The date on which the employer was notified of the injury.

DATE DISABILITY BEGAN – The date on which employee began losing time.

CONTACT NAME/PHONE NUMBER – Name and phone number of employer representative to be contacted for further information.

TYPE OF INJURY/ILLNESS – Briefly describe the nature of the injury or illness, (e.g., Lacerations to the forearm).

PART OF BODY AFFECTED – Indicate the part of body affected by the injury/illness, (e.g., Right Forearm, lower back).

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES – Mark yes or no as applicable.

TYPE OF INJURY/ILLNESS CODE – The NCCI code which corresponds to the nature of the injury or illness. (NCCI Table 8: Nature of Injury Codes)

PART OF BODY AFFECTED CODE – The NCCI code which corresponds to the part of the body injured. (NCCI Table 7: Part of Body Codes)

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED – Be specific (e.g., Maintenance Department or Client's office at 452 Monroe Street, Washington, D.C. 26210). If the accident or illness exposure did not occur on the employer's premises, enter address or location.

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED – List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint. Enter "NA" for not applicable if no equipment, materials, or chemicals were being used.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED – Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED – Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (e.g., walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL – Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

CAUSE OF INJURY CODE – The NCCI code which identifies the cause of injury. (NCCI Table 9: Cause of Injury Codes)

DATE RETURN(ED) TO WORK – Enter the date following the most recent disability period on which the employee returned to work.

IF FATAL, GIVE DATE OF DEATH – Date of death of employee.

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED/WERE THEY USED – Check applicable "yes" or "no" box.

PHYSICIAN/HEALTH CARE PROVIDER (NAME AND ADDRESS) – The name and address of the physician or health care professional providing initial treatment.

HOSPITAL (NAME AND ADDRESS) – The name and address of the hospital where employee was treated (if applicable).

INITIAL TREATMENT – Check applicable choices.

WITNESSES (NAME & PHONE #) – The name(s) and phone number(s) of any one who witnessed the accident.

DATE ADMINISTRATOR NOTIFIED – The date the carrier or claims administrator processing the claim received notice of the injury.

DATE PREPARED – The date this report was prepared.

PREPARER'S NAME & TITLE – The name and title of the person who prepared this report.

PHONE NUMBER – The phone number of the person who prepared this report.

NOTICE TO THE MISSISSIPPI WORKER'S COMPENSATION COMMISSION OF **PHYSICIAN OF CHOICE**

Employee's Name: _____

Employer's Name: _____

Date of Alleged Injury: _____

Claim Number: _____

I am claiming to have sustained an injury involving my _____

I am _____ am not _____ claiming that my medical condition is work related.

I understand that under the MS Worker's Compensation Law I have the right to choose one (1) physician to render treatment to me.

I also understand that any referral to any other physician must be made by my one (1) choose physician.

I also understand that my employer (or Worker's Compensation Carrier) must approve any physician change, and that if I change doctors without their authorization, I will be responsible for the medical expenses for the unauthorized treatment.

With that understanding, I state as follows:

_____ I accept as my choice of physician my employer's tender of treatment by

Dr. _____

_____ I elect to choose my own physician to render treatment, and that choice is

Dr. _____

_____
Employee's Name

_____
Employee's Signature

_____
Date

Witnessed by:

_____

_____

This Form Should Be Completed By Injured Employee Only

AUTHORIZATION AND CONSENT
TO RELEASE RECORDS AND PROTECTED HEALTH INFORMATION
(Excluding psychotherapy notes)

Name of Individual:
Social Security Number:
Date of Birth:

TO: All physicians, hospitals, clinics and institutions, pharmacists and other healthcare providers

The Veteran's Administration and all Veteran's Administration hospitals, clinics, physicians and employees

The Social Security Administration

The Internal Revenue Service

Open Records, Administrative Specialist, Department of Workers' Claims

All employers or other persons, firms, corporations, schools and other educational institutions

The undersigned individual hereby authorizes each entity included in any of the above categories to disclose and furnish to . and its authorized representatives, true and correct copies of all records, reports, files, documents, correspondence, memoranda and all other information related to the physical and mental health of the undersigned individual, regardless of the form of such information, including, without limitation, all notes of physicians, nurses, psychologists, counselors, dentists and other persons who have provided or who are providing health care to the undersigned individual, all radiology, pathology (including HIV test results and genetic testing information) and other diagnostic test and laboratory results, records and reports, all prescription records, all surgical procedure records and reports, all dental records, all histories and summaries, all forms and other information related to admission of the undersigned to or discharge of the undersigned from a clinic, hospital or other health care facility, all surgical procedure and other consent forms, all bills, invoices, claim forms, records and other payment information, including payment by Medicaid/Medicare and other public assistance programs, insurance companies and by other persons. Notwithstanding the broad scope of the above disclosure request, the undersigned does not authorize the disclosure of "psychotherapy notes" as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501.

The undersigned also authorizes the disclosure of all records, reports, files, documents, correspondence, memoranda and all other information related to employment of the undersigned, including attendance reports, performance reports, W-2 and W-4 forms, medical reports and/or any and all other records relating to my past and present employment, and all educational records, including all courses taken, degrees obtained, and attendance records.

The above list of types of records and other information to be disclosed is intended to be illustrative and not exhaustive.

- The undersigned individual is initiating this request for disclosure of protected health information, and any disclosure of the same pursuant hereto is at the request of the undersigned individual.

- The undersigned individual is hereby notified and acknowledges that any health care provider or health plan disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

- The undersigned individual is hereby notified and acknowledges that he or she may revoke this authorization by providing written notice either to _____ and/or to one or more entities listed in the above categories, except to the extent that any such entity has taken action in reliance on this authorization.

- The undersigned is hereby notified and acknowledges he or she is aware of the potential that protected health information disclosed and furnished to the recipient pursuant to this authorization is subject to redisclosure by the recipient in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

- A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the later of: (i) the date of settlement or final disposition of _____ *v.* _____, ***Cause No.*** _____ or (ii) five (5) years after the date of signature of the undersigned below.

I have carefully read and understand the above and do hereby expressly and voluntarily authorize the disclosure of all of my above information to _____ and its authorized representatives, by any entities included in the categories listed above.

Date: _____ _____
Signature of Individual or Individual's Representative

Individual's Name and Address: _____
Printed Name of Individual's Representative (If applicable)

_____ _____
Relationship of Representative to Individual (If applicable)

_____ _____

_____ _____
Description of Representative's authority to act for Individual (If applicable)

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act, and the regulations promulgated there under, 45 CFR Parts 160 and 164 (collectively, "HIPAA").

Claim #