



Telephonic Reporting: 1-800-327-3636 Workers' Compensation Call-In Script

The following script contains the comprehensive list of questions for your loss report. Asterisks denote information that is critical to proper handling office assignment. Please be sure to obtain this information prior to calling in a claim.

Preparer Information			
1. Preparer Name:	2. Preparer Phone:		
3. Filing State: *	4. Preparer's Title:		
5. Date of Loss: *	6. Time of Loss:		
7. Employee's Full Name: *	8. Employee Social Security Number:		
9. Is this a longshoreman claim: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Employer/Loss Location Information			
10. Policy Number: *	11. Account Number: *	12. Location Code:	
13. Account Name:	14. Employer Name:		
15. Address:	City:	State:	Zip Code:
16. Contact Work Phone:	17. FEIN:		
18. Mailing Address:	City:	State:	Zip:
19. Accident Location Name:			
20. Address:	City:	State:	Zip Code:
21. Is this the employer's premises? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Employee Information			
22. Employee Address:	City:	State:	Zip:
23. Home Phone:	24. Work Phone:	25. Alt Phone:	
26. Date of Birth:	27. Age:	28. Gender:	29. Marital Status:
30. Number of Dependent:	31. Primary Language:		
32. Regular Department:	33. Regular Occupation:		
34. EE injured in regular job Y/N/U:	35. NCCI Code:		
36. Check Correct Answer For Each: Is Employee a Partner: <input type="checkbox"/> Yes <input type="checkbox"/> No Owner: <input type="checkbox"/> Yes <input type="checkbox"/> No Officer: <input type="checkbox"/> Yes <input type="checkbox"/> No			
37. Supervisor's Full Name:	38. Supervisor Phone:		

Employment Information <small>If you answered 39, disregard 41/If you answered 42, disregard 43/ Only answer 1 of #49-52</small>		
39. Date of Hire:	40. State of Hire:	41. Length of Employment:
42. Date in Job:	43. Length in Current Job:	44. Employment Status:
45. (Answer if EE is temp/seasonal or terminated) Job End Date:	46. Hours Per Day:	47. Days Per Week:
48. Pay Type:	49. Hourly Wage :	
50. Daily Wage:	51. Weekly Wage:	52. Monthly Wage:
53. Gross Wages 30 days prior to accident: (AZ only)		
54. Time Shift Begins:		55. Time Shift Ends:
56. Regular Days Off (check): <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun		
57. Other Payments Not Reported:	58. Amount:	59. How Often is Other Payment Received: (Monthly, weekly, other)
60. Does Employee Consistently Receive Overtime:	61. Amount:	62. How is Overtime Payment Paid: (Monthly, weekly, other)
63. Date Injury Reported to Employer:		64. Employee Status at Time of Reporting: (CA only)
65. Date claim form provided to employee: (CA only)		
Loss Information		
66. Loss Description (what was employee doing at time of injury):		
67. Nature of injury:		68. Fatality Date:
Previously Reported Claims <small>If answer to 69 is YES please answer 70-72, if NO skip to #73</small>		
69. Has Employee previously reported a claim:		70. Loss Date:
71. Status (open/closed):		72. Body Part Injured:
Injury Information <small>(Current injury described in #66)</small>		
73. Has Employee missed time from work, or are they expected to? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
74. If so how many days?:		75. Has Employee returned to work: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
76. Date returned or expected to return:		77. Total estimated # of days lost:
78. Did EE return to regular or transitional duty:		79. Did Employee receive medical treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
80. Does employee have a Group Health Provider: (OR only) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		81. If yes, name of Group health provider:
82. Fifth day incapacity date: (MA only)		
Lost Time Information <small>(Answer #83-88 if EE is missing time from work, if NO disregard)</small>		
83. Last Day Worked:	84. Time EE left work:	85. Paid in full for date of inj?:

86. First day missed:	87. Did salary continue:	88. Late day EE paid in full:
Initial Treatment Information (Answer 89-102 if Treatment was received)		
89. Initial Treatment (first aid/clinic/ER):		
90. Taken by Emergency Transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		91. Airlifted/Medivac? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
92. Facility Name:		93. Phone:
94. Address:		City: State: Zip Code:
95. Facility Type (clinic/hospital):		96. Treating Physician:
97. Type of Medical Treatment Received:		
98. Admitted to Hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		99. Date Admitted:
100. Still in Hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
101. Intensive Care Unit: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		102. Burn Unit: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Additional Treatment (Answer 103-107 iff EE was referred or had follow-up)		
103. Physician Name:		
104. Address:		City: State: Zip Code:
105. Phone:		106. Specialty Type:
107. Type of Medical Treatment Received or Expected:		
Incident Information		
108. Time Employee Began Work:		109. Time Incident Reported:
110. Department Where Injury Occurred:		111. Were Safeguards or Safety Equipment provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
112. Were Safeguards or Safety Equipment Used: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
113. Is the purpose of this claim a possible Dispute? (LA only) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		114. OSHA log Number: (UT only)
115. Labor and Industrial claim number: (WA only)		116. UBI Number (WA only)
117. Could the employee have prevented the Accident: (VT only)		118. Could the employer prevent this type of accident: (VT only)
Additional Incident Information		
119. Was a Machine Part Involved: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		120. Was Machine Part Defective: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
121. In What Way Was the Machine Defective:		
122. Is The Claim Questionable: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		123. Was Employee Engaged in an Unsafe Activity: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
124. Was Employee Engaged in an Unsafe Activity: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		125. Describe Unsafe Activity:
Responsible Party (if applicable)		
126. Responsible Party Name:		127. Phone:
128. Address:		City: State: Zip Code:

Witness Information (if applicable)		
129. Witness Name:		
130. Address: _____ City: _____ State: _____ Zip Code: _____		
131. Home Phone: _____	132. Work Phone: _____	133. Alt Phone: _____
Contact Information		
134. Name: _____		
135. Address: _____ City: _____ State: _____ Zip Code: _____		
136. Work Phone: _____	137. Alt Phone: _____	138. Fax Number: _____
139. Email Address: _____		
140. Contact Person's Title: _____	141. When To Contact: _____	
Additional Information		

Jurisdictional Information
(Submit only for applicable states)

Nevada	
142. How is employee paid: (check one) <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Other	
143. Day of week pay period ends: (check one) <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat	
144. Are scheduled days off rotating: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	145. If part time, how many hours a week was the employee hired: _____ hrs
146. How many months has the employee been Employed by the current employer in NV: months	147. OSHA log number:
148. Was more than one person injured in the Accident: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	149. Supervisor that injury or occupational disease was reported to:
150. Was employee in your employ when the injured or disabled by occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	151. Did employee return to next scheduled shift after accident: <input type="checkbox"/> Yes <input type="checkbox"/> No
152. Will you have light duty work available if necessary: <input type="checkbox"/> Yes <input type="checkbox"/> No	153. Last day wages earned:
154. Unemployment Compensation received during last 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No	155. If validity of claim is doubted, state reason:
New Hampshire	
156. Is a NH youth employment certificate on file: <input type="checkbox"/> Yes <input type="checkbox"/> No	157. Estimated length of disability:
158. Number of full time employees:	159. Number of part time employees:
160. Is there a written safety program: <input type="checkbox"/> Yes <input type="checkbox"/> No	161. Is there an active Safety Committee: <input type="checkbox"/> Yes <input type="checkbox"/> No
162. Managed Care Program: <input type="checkbox"/> Yes <input type="checkbox"/> No	163. If yes, Managed care provider name:
Texas	
164. Does Employee speak English: <input type="checkbox"/> Yes <input type="checkbox"/> No	
165. If no, native language: <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Italian <input type="checkbox"/> Polish <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
166. Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic	
167. Tax ID number:	168. Last paycheck amount:
169. Last pay period hours worked:	170. Last pay period days worked:
171. Accident prevention services requested in past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No	172. If yes, Accident prevention services received: <input type="checkbox"/> Yes <input type="checkbox"/> No