MBA
Modern Business Associates

WORKERS' COMPENSATION CLAIM REPORTING PROCEDURES

1. Complete the enclosed First Report of Injury to ensure that you will have all of the appropriate questions answered during the reporting process. Have the employee sign the First Report of Injury. If the employee refuses to sign or is unable to sign, please note this on the First Report of Injury.

2. **Fax the completed First Report of Injury to MBA's Risk Management Department at 1.888.894.4622 or email it to wcinjuryreport@mbapeo.com.**

3. **Sign the Medical Authorization form and give it to the employee, along with one Chain of Custody form.**
   The Medical Authorization form will ensure that the medical bills are processed properly and that they are not being sent to the employer or injured employee.
   The Chain of Custody form is part of the MBA post-accident drug testing requirements.
   A Drug Test is REQUIRED on ALL reported incidents whether medical treatment is needed or not.

4. **For weekday work related injuries:**
   Send the injured employee to the nearest walk-in clinic with a signed Medical Authorization form and call MBA's Risk Management Department at 1.888.622.6460 to report the claim.

5. **For weekend, after hour or holiday work related injuries:**
   Send the injured employee to the nearest walk-in clinic with a signed Medical Authorization form and follow up with MBA's Risk Management Department at 1.888.622.6460 on the next business day.

6. **For any EMERGENCY or SERIOUS work related injuries:**
   Call 911 to have immediate treatment for the employee. Please be sure to provide the emergency medical technicians a signed Medical Authorization form.
   Calls MBA's Risk Management Department at 1.888.622.6460 and fax the completed First Report of Injury to 1.888.894.4622 **or email it to wcinjuryreport@mbapeo.com.**

7. The completed First Report of Injury will be transmitted to the appropriate claims handling office and a copy of the report will be kept on file by MBA for our records and claim auditing.

If you need additional help or information, please contact MBA's Risk Management Department at

1.888.622.6460

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MEDICAL AUTHORIZATION FORM

Employer:_____

Employee Name:_____

This is authorization for medical treatment arising from a job related injury being reported under Workers' Compensation Law. All billing and future authorizations should be directed to Modern Business Associates at the location shown below.

***** 10 panel drug screen is required on all work related injuries. Please fax results to MBA's Risk Management Department at 1-888-894-4622. *****

Manager's Signature:_____ Date:_____

Employee's Signature:_____ Date:_____

Modern Business Associates, Inc.
Attn: Risk Management Department
9455 Koger Blvd.
Suite 200
St. Petersburg, FL 33702
1.888.622.6460

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FIRST REPORT OF INJURY
1.888.622.6460

1. **PEO NAME: MBA**
2. **DATE OF INJURY: _____ TIME OF INJURY: _____ AM PM**
3. **INJURED WORKER – NAME: _____**

   ADDRESS: _____

   CITY:_____ STATE:_____ ZIP: _____

   SOCIAL SECURITY #: _____PHONE#: (____) _____
4. **MARITAL STATUS: SINGLE_____ MARRIED _____ DIVORCED_____**
5. **DATE OF HIRE: _____/_____/_____ DATE OF BIRTH:_____/_____/_____**
6. **OCCUPATION: _____ W/C CLASS CODE:_____**
7. **DATE RETURNED TO WORK: SAME DAY_____ NEXT DAY_____**
   FULL DUTY_____ LIGHT DUTY _____
8. **CLIENT NAME: _____ CLIENT NUMBER_____**

   ADDRESS:_____

   CITY:_____ STATE:_____ ZIP:_____

   Phone #:_____ COUNTY:_____
9. **PLACE OF ACCIDENT, if different from client location:**

   ADDRESS:_____

   CITY:_____ STATE:_____ ZIP:_____
10. **DESCRIPTION OF ACCIDENT: _____**
    _____
11. **TYPE OF INJURIES: _____**
12. **TREATING FACILITY OR PHYSICIAN: _____**

    ADDRESS:_____

    CITY:_____ STATE:_____ ZIP:_____
13. **DATE INJURY REPORTED TO EMPLOYER: _____/_____/_____**
14. **IS EMPLOYER AWARE OF ANY PRE-EXISTING CONDITIONS THAT MAY APPLY? _____**
15. **IS THERE ANY DOUBT OR QUESTION AS TO THE VALIDITY OF THE INJURY? _____YES _____NO**
16. **WAS THERE ANY OTHER PERSON OR EQUIPMENT THAT MAY HAVE BEEN THE CAUSE OF THE INJURY? _____**

COMPLETED BY: _____ DATE: _____

I understand that any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits a criminal offense. I attest that the above information is true and correct.

Employee Signature: _____ Date: _____

PLEASE FAX COMPLETED FORM TO: 1.888.894.4622 OR EMAIL IT TO
wcinjuryreport@mbapeo.com

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Acknowledgment of Refusal to Submit to Post-Accident Drug Test

I, _____, hereby acknowledge that I have refused to submit to a post-accident drug test as required by my employer. I understand that refusing to submit to a post-accident drug test may lead to disciplinary action, up to and including termination, and may result in a loss of workers' compensation and/or unemployment compensation benefits.

_____ _____
Employee Date

_____ _____
Direct Supervisor Date

_____ _____
Witness Date

cc: Personnel File

Customized Solutions for Your HR Peace of Mind

MBA
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Acknowledgment of Refusal of Medical Treatment

I, _____, hereby acknowledge that I have refused to be medically evaluated for a work related injury I sustained on _____. I understand that by signing this document any future claims regarding this injury will require me to notify my supervisor immediately. I also understand that even though I require no medical treatment for this injury I still must adhere to a mandatory drug screen.

_____ _____
Employee Date

_____ _____
Direct Supervisor Date

_____ _____
Witness Date

cc: Personnel File (MBA)

Customized Solutions for Your HR Peace of Mind