MBA
Modern Business Associates

WORKERS' COMPENSATION CLAIM REPORTING PROCEDURES

1. Complete the enclosed First Report of Injury **within 24 hours of notification 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. **Provide Employee with the California Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility upon notification of injury**. Employee should complete the top section of the DWC1 and Manager to complete the lower employer section. This should be faxed to MBA with the completed first report of injury.

3. ***Immediately*** **Fax the completed First Report of Injury & DWC1 to MBA's Risk Management Department at 1.888.894.4622 or email it to wcinjuryreport@mbapeo.com.** If available, please send any medical notes from the treating physician or hospital.

4. **Sign the Medical Authorization form and give it to the employee to take to Medical Facility for treatment**
   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.

5. **For weekday work related injuries:**
   Send the injured employee to the nearest identified medical facility (on the approved provider list) with a signed Medical Authorization form and call MBA's Risk Management Department at 1.888.622.6460 to report the claim.

6. **For weekend, after hour or holiday work related injuries:**
   Send the injured employee to the nearest identified medical facility (on the approved provider list) 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.

7. **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.
   Call 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.**

8. 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.

Manager's
Signature:_____ Date:_____

Employee's
Signature:_____ Date:_____

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

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FIRST REPORT OF INJURY
Fax to 1.888.622.6460

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

   ADDRESS: _____

   CITY: _____ **STATE:** _____ **ZIP:** _____

   SOCIAL SECURITY #: _____ **PHONE#:** _____
3. **MARITAL STATUS: SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐
4. **DATE OF HIRE:** _____ _____ _____ **DATE OF BIRTH:** _____ _____ _____
5. **OCCUPATION:** _____ **W/C CLASS CODE:** _____
6. **RETURNED TO WORK: YES** _____ **NO** _____ **SAME DAY** _____ **DATE RETURNED** _____
7. **EMPLOYEE RETURNED 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 (be as specific as possible):** _____
    _____
    _____
11. **TYPE OF INJURIES (be as specific as possible)::** _____
    _____
12. **TREATING FACILITY OR PHYSICIAN:** _____
    ADDRESS: _____
    CITY: _____ **STATE:** _____ **ZIP:** _____
    PHONE: _____
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?** _____
17. **WERE THERE ANY WITNESSES?** ☐ **YES** ☐ **NO**

    NAMES: _____

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 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.

_____ _____
Employee Date

_____ _____
Direct Supervisor Date

_____ _____
Witness Date

cc: Personnel File (MBA)