



## **WORKERS' COMPENSATION CLAIM REPORTING PROCEDURES**

1. In the event of an employee incident, complete the attached First Report of Incident and forward to MBAadvisors **within 24 hours of notification of incident**. Have the employee sign the First Report of Incident. If the employee refuses to sign or is unable to sign, please note this on the First Report of Incident. Fax the completed First Report of Incident to MBAadvisors Risk Management department at 1.888.894.4622 or email it to [wcinjuryreport@MBAadvisors.com](mailto:wcinjuryreport@MBAadvisors.com). If available, please send any medical notes from the treating physician or hospital.
2. 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 employee. The Chain of Custody form is part of the MBAadvisors post-accident drug testing requirements.  
**A Drug Test is REQUIRED on ALL reported incidents whether medical treatment is needed or not.**
3. 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 Chain of Custody form. Fax the completed First Report of Incident to MBAadvisors' Risk Management Department at 1.888.894.4622 or email it to [wcinjuryreport@MBAadvisors.com](mailto:wcinjuryreport@MBAadvisors.com).
4. For weekend, after hours, 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 Chain of Custody. Fax the completed First Report of Incident to MBAadvisors Risk Management department at 1.888.894.4622 or email it to [wcinjuryreport@MBAadvisors.com](mailto:wcinjuryreport@MBAadvisors.com). Follow up with MBAadvisors' Risk Management Department at 1.888.622.6460 on the next regular business day.
5. 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 MBAadvisors' Risk Management Department at 1.888.622.6460 and fax the completed First Report of Incident to 1.888.894.4622 or email it to [wcinjuryreport@MBAadvisors.com](mailto:wcinjuryreport@MBAadvisors.com).
6. The completed First Report of Incident will be transmitted to the appropriate claims handling office and a copy of the report will be kept on file by MBAadvisors for our records and claim auditing.

**If you need additional help or information, please contact MBAadvisors Risk Management Department at  
1.888.622.6460**



**MEDICAL AUTHORIZATION FORM**

Employer: Modern Business Associates L/C/F \_\_\_\_\_  
(Client name here)

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 MBAdivisors at the location shown below.

**\*\*\* A 10 panel drug screen is required on all work related injuries. Please fax drug screen results, a copy of the COC, along with any office notes to MBAdivisors Risk Management Department at 1-888-894-4622. \*\*\***

Manager's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

MBAdivisors  
Attn: Risk Management Department  
9455 Koger Blvd.  
Suite 200  
St. Petersburg, FL 33702  
1.888.622.6460



**FIRST REPORT OF INCIDENT**  
**FAX to 888.894.4622**

1. Date of incident: \_\_\_\_\_ Time of incident: \_\_\_\_\_ am \_\_\_\_ pm \_\_\_\_
2. Date incident reported to employer: \_\_\_\_/\_\_\_\_/\_\_\_\_
3. Employees Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_  
 Zip: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_
4. Date of Hire: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
5. Job Title: \_\_\_\_\_ w/c class code: \_\_\_\_\_
6. Did the employee return to work? Yes\_\_\_\_ No\_\_\_\_ Same Day\_\_\_\_ Date Returned \_\_\_\_\_
7. Client name: \_\_\_\_\_ Client Number: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_  
 Zip: \_\_\_\_\_ County: \_\_\_\_\_ Phone #:(\_\_\_\_) \_\_\_\_\_
8. Place of incident, *if different from client location*: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_
9. Describe what happened (be as specific as possible): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
10. What was the employee doing at the time of incident: \_\_\_\_\_  
 \_\_\_\_\_
11. Describe the injuries and body part(s) affected (be specific): \_\_\_\_\_  
 \_\_\_\_\_
12. Did the employee receive medical treatment? Yes\_\_\_\_ No\_\_\_\_  
 If Yes, please state the treating facility or physician: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_  
 Zip: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_
13. Was employee sent for the mandatory drug screen: Yes\_\_\_\_ No\_\_\_\_  
 If No, did the employee refuse the mandatory drug test? Yes\_\_\_\_ No\_\_\_\_  
 If Yes, did the employee sign the proper refusal form? Yes\_\_\_\_ No\_\_\_\_



14. Is employer aware of any pre-existing conditions that may apply? Yes\_\_\_\_ No\_\_\_\_

If Yes, Please state what conditions 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 incident?

Yes\_\_\_\_ No\_\_\_\_

If Yes, Please explain: \_\_\_\_\_

17. Were there any witnesses? Yes\_\_\_\_ No\_\_\_\_

Please provide Name(s) and Job Title(s): \_\_\_\_\_

\_\_\_\_\_

18. Was any personal protective equipment required? Yes\_\_\_\_ No\_\_\_\_

If Yes, please list all personal protective equipment required (i.e. slip resistant shoes, cut resistant gloves, etc.) \_\_\_\_\_

\_\_\_\_\_

If Yes, was the employee using the proper personal protective equipment?

Yes\_\_\_\_ No\_\_\_\_

19. Was the proper safety training provided to the injured employee? Yes\_\_\_\_ No\_\_\_\_

If no, please explain: \_\_\_\_\_

\_\_\_\_\_

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@MBAadvisors.com](mailto:wcinjuryreport@MBAadvisors.com)**



## Acknowledgment of Refusal to Submit to Post-Incident Drug Test

I, \_\_\_\_\_, hereby acknowledge that I have refused to submit to a post-incident drug test as required by my employer. I understand that refusing to submit to a post-incident 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



## Acknowledgment of Refusal of Medical Treatment

I, \_\_\_\_\_, hereby acknowledge that I have refused to be medically evaluated for a work related incident on \_\_\_\_\_. I understand that by signing this document any future claims or treatment relating to this incident 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 post-incident drug screen.**

\_\_\_\_\_  
Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Direct Supervisor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Cc: Personnel File