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WORKERS' COMP CLAIM REPORTING PROCEDURES

1. In the event of an employee incident, complete the attached First Report of Incident and forward to MBA **within 24 hours of notification of incident**. Or access the forms online https://www.mbahro.com/resources/

- If not completing online, fax the completed First Report of Incident to the Risk Management department at 1.888.894.4622
- Or email it to wcinjuryreport@mbahro.com.
- 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.
- 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. Or utilize the e-screen portal to create a Chain of Custody form for the employee.
   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.

   A post-accident drug screen is REQUIRED on ALL reported incidents whether medical treatment is needed or not.

3. Send the injured employee to a medical facility on the approved provider list, with a signed Medical Authorization form and Chain of Custody form. If not completed online, fax the completed First Report of Incident to MBA's Risk Management Department at 1.888.894.4622 or email it to wcinjuryreport@mbahro.com.

   *If possible, follow up with MBA's' Claim Department at 1.888.622.6460.

4. 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 Incident to 1.888.894.4622 or email it to wcinjuryreport@mbahro.com.

5. The completed First Report of Incident will be transmitted to the appropriate insurance claims handling office and a copy of the report will be kept on file by MBA.

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

1.888.622.6460

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EMPLOYEE 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 MBA at the location shown below.

***** A 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 MBA Risk Management Department at 1-888-894-4622 or email wcinjuryreport@mbahro.com *****

Manager's Signature: _____ Date: _____

Employee's Signature: _____ Date: _____

MBA Risk Management Department
9455 Koger Blvd. Suite 200
St. Petersburg, FL 33702
1.888.622.6460
wcinjuryreport@mbahro.com

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FIRST REPORT OF INCIDENT

Fax to 888.894.4622 or email
wcinjuryreport@mbahro.com

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____

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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@mbahro.com.

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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

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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 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