MCSIP

Montgomery County
Self–Insurance Program

How to Report Employee Work-Related Injuries/Illnesses

All work-related injuries/illnesses must be reported regardless of whether or not the employee seeks treatment. Supervisors of employees who suffer a work-related injury or illness must report this injury or illness.

Reports can be made 24 hours a day, seven days a week by calling 1-888-606-2562. When calling to report the injury/illness, the supervisor will be asked several questions. The following checklist can assist in gathering and reporting the necessary information.

Call 1-888-606-2562.

A Customer Service Representative will answer the phone you will hear "Thank you for calling the Montgomery County Self-Insurance Program claims reporting Line. This is __. May I have the location name you are calling in reference to?"

You will need the following information when calling in a first report of injury or illness:

1. **Location/Employer**
   Identify both the employer and your department name.

   Location Code # should be offered if known. _____

2. **Employer's Address**
   Provide the Department address of the injured/ill employee.

   Street Address _____

   City, MD Zip Code _____

3. **Incident/ Illness**
   Injured Employee name_____
   (First, Middle, Last)

   Employee Social Security No.: _____

   Date of Injury (If date is unknown, use the date the injury was first reported to employee's supervisor.)
   _____

   Medical Treatment Expected
   ☐ No ☐ Yes

   What State did injury occur? _____

   Employee Number
   Home: _____ Work: _____

   Employee email address _____

4. **Injury/Accident Detail**

   Severity of injury (Choose one)
   ☐Minor (no medical treatment necessary)
   ☐Moderate (outpatient medical treatment necessary)
   ☐Severe (Hospital visit via emergency transport or overnight stay)

   Treating Physician
   Name: _____
   Address: _____
   Phone No.: _____

   Treatment (Pick One)
   ☐First Aid ☐Clinic ☐Emergency Room
   ☐Fatality ☐Hospitalized <24
   ☐Hospitalized overnight ☐Inpatient

   Time injury occurred _____ (AM/PM)

   Body part injured _____ ☐Right ☐Left

At this time you will be asked where the **Treatment Form** should be sent. The Treatment Form will include important information necessary for the injured worker to share with the treating physician or pharmacist. The Treatment Form can be sent by email or fax. The Treatment Form is not the FNOL.

You will now continue on to the First Notice of Loss (FNOL) Questions

5. **Employer Information**
   If the employer's address is the same as provided above, indicate that to the Representative. Otherwise, provide the street number, street name, City, State, Zip Code, and number.

   ☐ Same as above; or

   Street Address _____

   _____, MD Zip Code _____
   (City)

   Employers Phone Number _____

Revised June 6, 2012

6. **Injured Employee Information**
Employee's Home Address
Street address _____
City _____
State_____ Zip Code _____

Date of Birth:_____

Employee Gender: ☐Male ☐Female

Employee Marital Status

_____

Employee's Number of Dependents
(Do not include the employee in this number)
_____

Employee Date of Hire: _____

_____

Employee State of Hire – Always **Maryland**

Employee Job Title _____

Employee Employment Status
☐Full Time ☐Part Time ☐Volunteer

7. **Wage Information**
Wage Rate (If available)
$_____ ☐Day ☐Week ☐Month ☐Other

Number of Hours Worked Per Day
☐ 7hrs ☐ 8hrs ☐ Other _____

Number of days worked per week
☐ 5 days ☐ other

Will the employee be paid in full for the day of injury? (If the employee is full-time, did they receive full pay for the day? If part-time, did they receive full pay for the time they were scheduled to work?)
☐Yes ☐No

Will the employee's salary continue? (If claim is for lost time and the employee is salaried, will they continue to be paid during the period of lost time?)
☐Yes ☐No

8. **Occurrence**

A.)What time did the employee begin work?

B.)What time did the injury or illness occur?

C.)What date was last worked by the employee?

D.)What date was the employer notified that there was an injury or occurrence?

E.)What date did the disability begin?

F.)Employee's supervisor:
Name: _____
Number: _____

G.)Describe the type of injury. _____

H.)Did the injury or illness occur on employer's premises? _____

I.)Identify the department or location where accident, illness, or exposure occurred. _____

J.)Be prepared to provide a detailed description of the incident. Specify activity the employee was engaged in when the accident or illness exposure occurred. Work process the employee was engaged in when accident or illness exposure occurred.
_____
_____
_____
_____

K.)How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured he employee or made the employee ill.
_____
_____
_____

L.) What was the cause of injury? _____
M.)Has the employee retuned to work? If so, what date? _____

N.)Did injury or illness result in fatality? ☐Yes ☐No
If yes, what was the date of death?

9. **Additional safety questions**
Were safeguards or safety equipment provided, if so the type provided; if not provided, why not. Was the safeguard or equipment used, if so the type used? Would the use of the safety equipment have prevented the injury?

10. **If medical treatment received please provide**
Health care provider name _____
Health care provider address _____
Hospital name _____
Hospital address_____
Initial treatment:
☐First Aid
☐Clinic
☐Emergency Room
☐Fatality
☐Hospitalized <24 hours
☐Hospitalized overnight
☐Inpatient

11. **Provide witness information**

    Name _____

    Number: _____

If there are multiple witnesses, provide information for each individual.

12. **Provide the callers full name, job title and telephone number.**

The Customer Service Representative will then ask the following questions regarding the injury/illness. The following information will not be included with the FNOL. Be prepared to provide the following information:

13. Was the employee in the course and scope of employment when the alleged injury occurred?

14. Where there any witness confirming the accident or injury?

15. What is the severity level of this injury (pick one)?

    ☐Minor (no medical treatment necessary)
    ☐Moderate (outpatient medical treatment necessary)
    ☐Severe (Hospital visit via emergency transport or overnight stay)

16. For which state are payroll taxes withheld for the employee?

17. What is the employee's cell phone number?

18. What is the name of the union the employee belongs to?

19. Is the injured employee opting to be treated within the workers compensation network (CorVel PPO)?

20. Provide any additional information you feel will be helpful with the investigation of the claim.

21. Prior to the call ending, a ten digit claim number (XX-XX-XXXXXX) will be provided.

The WC Workers' Compensation Carrier representative is:

CorVel Corporation
Post Office Box 44015
Baltimore, MD 21236
(800)234-5003

Additional helpful information can be found on the Montgomery County Self-Insurance Program website.

www.mcsip.org