Workers' Compensation Guide For FMS

1 Report the Injury or Illness

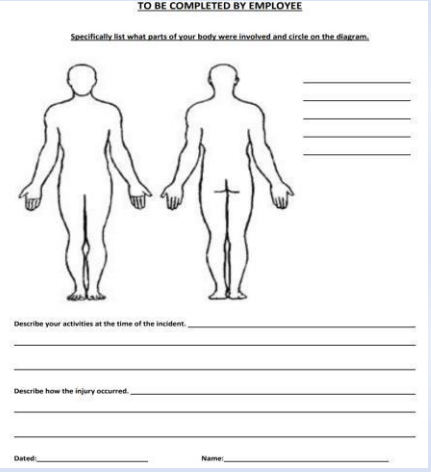
As soon as an employee reports a job-related injury or illness, you must print out the Mains'l Claim Packet and fill in the Claim Information Report. Fill in as much information as possible and email or fax to WCMC within **24 hours of notice of injury**. Contact information: Fax 651-501-1493 or Email- claims@wcmcinc.com Additionally, inform Human Resources that this process has been started.

2 Ask Employee to be Evaluated

Provide the employee with the Workers' Compensation Claim Form (DWC1) to take with them to an in-network WCMC provider to be evaluated. To find in network providers in your area, please visit https://goperspecta.com/VPD/berkshirehathawayCAMPN/public/ProviderSearch/Main The employee will need to fill out the top section of this form labeled "Employee" and is located on page 4 of the DWC1 form.

3 Send in Documentation

After the employee has been evaluated by the doctor, ask them to complete the CA-Mains'l Claim Packet. They will need to describe their injury completely including every part of the body on the body diagram and sign and date authorization forms. Once this is completed, send the DWC1 and the Claim Packet to WCMC and HR.


TO BE COMPLETED BY EMPLOYEE

Specifically list what parts of your body were involved and circle on the diagram.

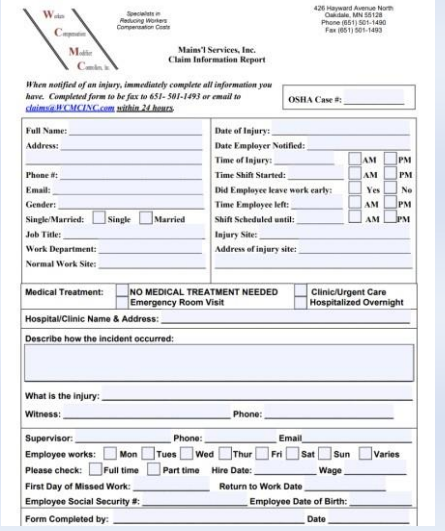
Describe your activities at the time of the incident.

Describe how the injury occurred.

Dated: Name:

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)


Mains'l Services, Inc.
Claim Information Report

426 Hayward Avenue North
Oakdale, MN 55128
Phone (651) 501-1490
Fax (651) 501-1493

When notified of an injury, immediately complete all information you have. Completed form to be fax to 651- 501-1493 or email to claims@WCMCINC.com within 24 hours.

OSHA Case #:

Full Name:
Address:
Phone #:
Email:
Gender:
Single/Married: Single Married
Job Title:
Work Department:
Normal Work Site:

Date of Injury:
Date Employer Notified:
Time of Injury: AM PM
Time Shift Started: AM PM
Did Employee leave work early: Yes No
Time Employee left: AM PM
Shift Scheduled until: AM PM
Injury Site:
Address of injury site:

Medical Treatment: NO MEDICAL TREATMENT NEEDED Clinic/Urgent Care Emergency Room Visit Hospitalized Overnight
Hospital/Clinic Name & Address:
Describe how the incident occurred:
What is the injury:
Witness: Phone:
Supervisor: Phone: Email
Employee works: Mon Tues Wed Thur Fri Sat Sun Varies
Please check: Full time Part time Hire Date: Wage
First Day of Missed Work: Return to Work Date
Employee Social Security #: Employee Date of Birth:
Form Completed by: Date

WCMC

426 Hayward Ave North

Oakdale, MN 55128

Phone: (651) 501-1490

Fax: (651) 501-1493

Email: claims@wcmcinc.com

https://www.netbyd.com/nbdmpn/

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https://www.Mainsl.com

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