Workers Compensation Modifier Controllers, Inc.

Specialists in Reducing Workers Compensation Costs

426 Hayward Avenue North
Oakdale, MN 55128
Phone (651) 501-1490
Fax (651) 501-1493
claims@wcmcinc.com

Incident Checklists

- **Management immediately fill out 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 below.**
  - **Fax 651-501-1493**
  - **Email: claims@wcmcinc.com**
- **Request employee to complete body diagram and sign and date authorization forms. Return all forms to WCMC (fax or email above) and your management.**
- **MEDICAL ATTENTION IS NOT REQUIRED. If an employee decides to seek treatment, please request the employee present the Light Duty Form to the doctor and return it to management and WCMC after appointment.**
- **The billing information sheet should also be provided to the medical facility.**
- **Light Duty Work will be available to accommodate any restrictions set by the doctor.**
- **Stay in constant contact with WCMC regarding the employee's status or other information relative to this injury.**

***DISCLAIMER** It is the responsibility of the employer, not the employee, to fill out the Claim Information Report. The employee is not required to physically come into your office to advise you of an injury. It is the requirement of the employer to immediately notify us of the claimed injury.*

Call WCMC at 651-501-1490 with any questions.

WE ARE HERE TO HELP!

PROPRIETARY DOCUMENT: This form is the proprietary work product of WCMC (Workers Compensation Modifier Controllers, Inc.). This form cannot be posted on any public on-line platform without the expressed written consent of WCMC and access to it for the purpose of completion and execution must be password protected when posted for internal use. This form is invalid when used by any entity other than WCMC or a current client of WCMC.

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Mains'l Services, Inc.
Claim Information Report

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: _____
City,State,Zip_____
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
Where were you when injury occurred:_____
_____
Address of injury site:_____
_____

Medical Treatment: ☐ **NO MEDICAL TREATMENT NEEDED** ☐ **Clinic/Urgent Care** ☐ **Emergency Room Visit** ☐ **Hospitalized Overnight**

Hospital/Clinic Name & Address: _____

Describe incident resulting in the injury:

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: _____

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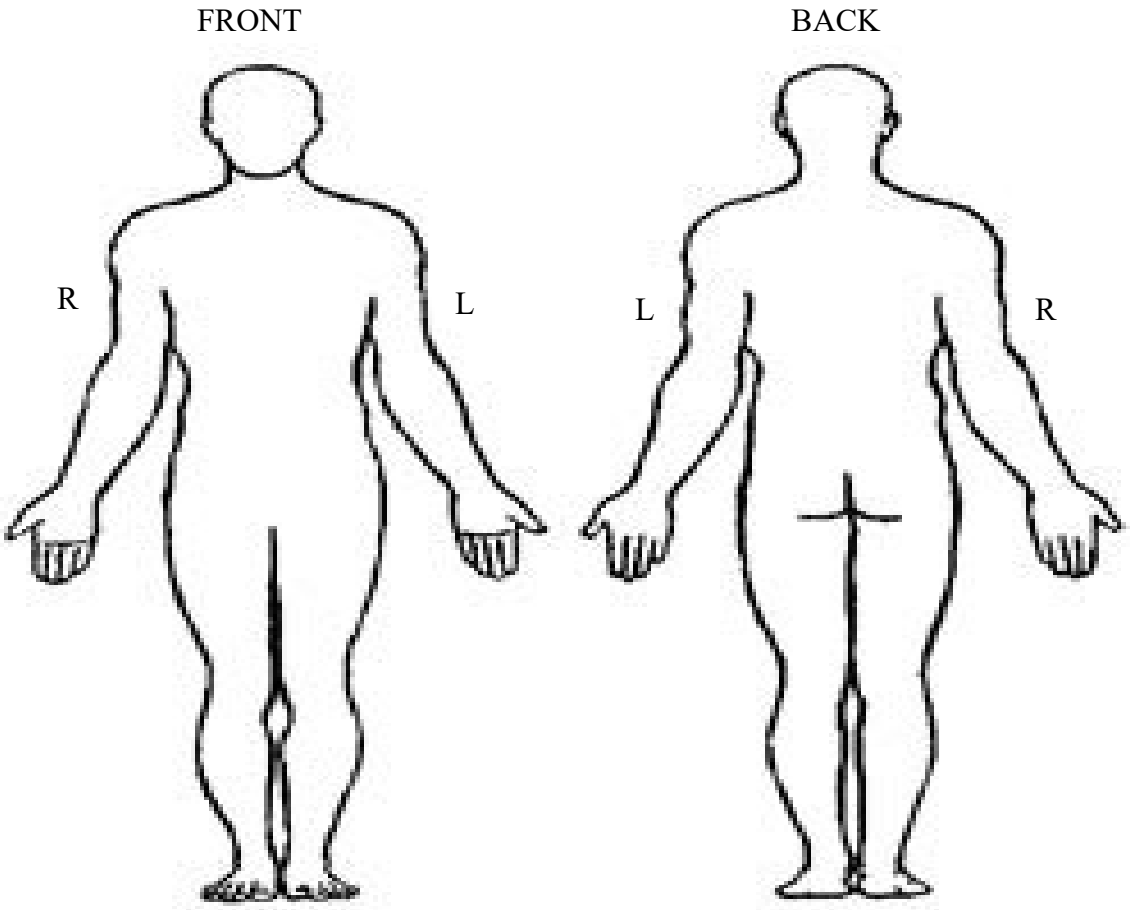
Must be filled out by employee.
Description of Injury Form

Circle all injured body parts.



List the body parts injured, (example: right wrist):

_____

_____

_____

Describe the incident which resulted in the injury, (example: slipped and fell in parking lot due to snow):

_____

_____

_____

_____

Employee's Name: _____

Employee's Signature: _____ Date: _____

PRINT CLEAR

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it "**Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
_____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
_____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. ❑ Check if you agree to receive notices about your claim by email only. ❑ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____.

You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*

9. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

10. Name of employer. *Nombre del empleador.* _____
11. Address. *Dirección.* _____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.*_____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
Berkshire Hathaway Homestate Companies, PO Box PO Box 881716, San Francisco, CA 94188-1716
16. Insurance Policy Number. *El número de la póliza de Seguro.* **MAWC652602**
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/*Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*

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Physical Restrictions Form

Fax form to 651-501-1493 or claims@wcmcinc.com

*******WE VALUE OUR EMPLOYEES! WE OFFER MODIFIED DUTY! *******

We respectfully request that you do not completely disable our employee if it is not medically necessary to do so. It is the policy of Mains'l Services, Inc to offer temporary-transitional, light duty work.

Employee Name: _____ Today's Date: _____Injury Date: _____

Diagnosis_____ Body Part/s Involved: _____

To ensure the best recovery possible, please indicate below the physical restrictions should be followed **24/7, (at work and at home**).

_____

_____

_____

_____

Restrictions effective until:_____ Date of follow up appointment (if needed): _____

Physician Name (print) _____Physician Signature_____

Clinic/Hospital _____

Instructions for this form: Employee: Please provide this form to your supervisor following the medical appointment.

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Please Provide to Doctor's Office

For a claim number or questions about the claim, please call our workers' compensation representative at 651-501-1490.

Our workers' compensation insurance carrier is:

Berkshire Hathaway

PO BOX 881716

SAN FRANCISCO, CA 94188-1716

Phone: 800-661-6984

Please immediately fax all workability reports to 651-501-1493.