WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL. ZIP)
MS State Agencies SIWCT
P. O. Box 24208
Jackson MS 39225

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION
Mississippi

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYERS LOCATION ADDRESS (IF DIFFERENT)

LOCATION #:

PHONE #

SIC CODE

EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO.)

POLICY PERIOD
TO

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)
CCMSI
P. O. Box 1378
Ridgeland MS 39158-1378

CARRIER FEIN

POLICY/SELF-INSURED NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL. ZIP)

SEX
☐ MALE
☐ FEMALE
☐ UNKNOWN

MARITAL STATUS
☐ UNMARRIED SINGLE/DIVORCED
☐ MARRIED
☐ SEPARATED
☐ UNKNOWN

OCCUPATION JOB TITLE

EMPLOYMENT STATUS

PHONE

NCCI CLASS CODE

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO
DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGA

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSU RE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

DEPARTM ENT O R LOCATION WHE RE ACC IDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT. MATERIALS. OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS ME EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE ME SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO
WERE MEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT
☐ NO MEDICAL TREATMENT
☐ MINOR: BY EMPLOYER
☐ MINOR CLINIC/HOSP
☐ EMERGENCY CARE
☐ HOSPITALIZED> 24 HRS
☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

IAIABC-IA-1 (4/96)

SEE BACK FOR INSTRUCTIONS

WORKERS' COMPENSATION - FIRST REPORT OF INJURY EMPLOYER'S INSTRUCTIONS

GENERAL INFORMITION

EMPLOYER (NAME & ADDRESS INCL ZIP) -- The name and address of the entity employing or statutorily responsible for the employee.

SIC CODE – The code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

EMPLOYER FEIN – Employer's Federal Employer Identification Number.

CARRIER/ADMINISTRATOR CLAIM NUMBER -- Carrier's claim or file number.

REPORT PURPOSE CODE – A code used with Electronic Data Interchange to define the specific purpose of the report. (Original, Cancel, Change, Correction)

JURISDICTION – State in which you are filing the claim (Mississippi).

JURISDICTION CLAIM NUMBER – Number assigned to claim by Mississippi Workers' Compensation Commission (to be completed by MWCC).

INSURED REPORT NUMBER -- The number, if any, used by the employer to identify the claim.

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) – The name and address of the employeis facility where the employee was employed at the time of injury, if different from above.

LOCATION # PHONE # – The number, if any, assigned by the employer to identify its location where the injury occurred and the phone number.

CARRIER (NAME, ADDRESS & PHONE NO) – The licensed business entity issuing the contract of insurance and assuming financial responsibility for the claim on behalf of the employer.

POLICY PERIOD – The date that the contract/policy under which the claim occurred began and expired.

CHECK IF APPROPRIATE (SELF-INSURANCE) – An indicator that identifies the employer as one who retains the risks arising from their operations and bears the financial responsibility. A jurisdictionally approved or acknowledged employer, group fund, or association assuming financial risk and responsibility for their employee's worker's compensation claims.

CLAIMS ADMINISTRATOR – The business entity providing claim services on behalf of the carrier, or self-insured. The name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

CARRIER FEIN – Carrier's Federal Employer Identification Number.

POLICY/SELF-INSURED NUMBER – The number assigned by the carrier to the insurance contract/policy for the employer; or any similar number assigned to a self-insured employer.

ADMINISTRATOR FEIN -- Federal Employer Identification Number of Administrator.

AGENT NAME & CODE NUMBER – The name of the insurance agent and the agents code number if known. This information should be found in the insurance policy.

EMPLOYEE/WAGE INFORMATION

NAME (LAST, FIRST, MIDDLE) – Employee's legally recognized name.

ADDRESS -- The mailing address used by the employee.

PHONE – A telephone number where the employee can be reached.

DATE OF BIRTH – The date the employee was born.

SOCIAL SECURITY NUMBER – A number assigned by the Social Security Administration used to identify the employee.

DATE HIRED – The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.

STATE OF HIRE – State where employee was hired.

SEX – The code which indicates the sex of the employee.

MARITAL STATUS – The code which indicates the marital status of the employee.

OCCUPATION/JOB TITLE – This is the primary occupation of the employee at the time of the accident or exposure.

EMPLOYMENT STATUS-- Indicate the employee's work status. The valid choices are: Full-time, Part-Time, Not Employed, On Strike, Disabled, Retired, Unknown, Apprenticeship Full-Time, Apprenticeship Part-Time, Volunteer, Seasonal, or Piece Worker.

NCCI CLASS CODE – A code which corresponds to the primary occupation which the employee was engaged at the time of accident/injury, or injurious exposure. Codes are found in the NCCI BASIC MANUAL FOR WORKERS' COMPENSATION AND EMPLOYERS LIABILITY INSURANCE.

RATE – The reported employee's wage rate at the time of injury.

 # DAYS WORKED/ WEEK – The number of days worked by the employee in a week.

FULL PAY FOR DAY OF INJURY -- State whether employee was paid his full wages on the injury date.

DID SALARY CONTINUE – State whether employee's salary was continued by the employer in lieu of compensation benefits.

OCCURRENCE/TREATMENT INFORMATION

TIME EMPLOYEE BEGAN WORK – The time employee began work on date of injury.

DATE OF INJURY/ILLNESS — The date employee was injured.

TIME OF OCCURRENCE – The time employee was injured.

LAST WORK DATE-- The date employee last worked following the injury.

DATE EMPLOYER NOTIFIED – The date on which the employer was notified of the injury.

DATE DISABILITY BEGAN – The date on which employee began losing time.

CONTACT NAME/PHONE NUMBER -- Name and phone number of employer representative to be contacted for further information.

TYPE OF INJURY/ILLNESS – Briefly describe the nature of the injury or illness, (e.g., Lacerations to the forearm).

PART OF BODY AFFECTED – Indicate the part of body affected by the injury/illness, (e.g., Right Forearm, lower back).

DID INJURYIILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES – Mark yes or no as applicable.

TYPE OF INJURY/ILLNESS CODE -- The NCCI code which corresponds to the nature of the injury or illness. (NCCI Table 8: Nature of Injury Codes)

PART OF BODY AFFECTED CODE – The NCCI code which corresponds to the part of the body injured. (NCCI Table 7: Part of Body Codes)

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED – Be specific (e.g., Maintenance Department or Client's office at 452 Monroe Street, Washington, D.C. 26210). If the accident or illness exposure did not occur on the employer's premises, enter address or location.

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED – List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint. Enter "NA" for not applicable if no equipment, materials, or chemicals were being used.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED – Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED – Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (e.g., walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL -- Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding, to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

CAUSE OF INJURY CODE – The NCCI code which identifies the cause of injury. (NCCI Table 9: Cause of Injury Codes)

DATE RETURN(ED) TO WORK – Enter the date following the most recent disability period on which the employee returned to work.

IF FATAL, GIVE DATE OF DEATH -- Date of death of employee.
WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDEDMIERE THEY USED - Check applicable "yes" or "no" box.

PHYSICIAN/HEALTH CARE PROVIDER (NAME AND ADDRESS)– The name and address of the physician or health care professional providing initial treatment.

HOSPITAL (NAME AND ADDRESS) – The name and address of the hospital where employee was treated (if applicable).

INITIAL TREATMENT – Check applicable choices.

WITNESSES (NAME & PHONE #) – The name(s) and phone number(s) of any one who witnessed the accident.

DATE ADMINISTRATOR NOTIFIED – The date the carrier or claims administrator processing the claim received notice of the injury.

DATE PREPARED – The date this report was prepared.

PREPARER'S NAME & TITLE – The name and title of the person who prepared this report.

PHONE NUMBER -- The phone number of the person who prepared this report.

NOTICE

TO

MISSISSIPPI WORKERS' COMPENSATION COMMISSION

OF PHYSICIAN CHOICE

Claimant's Name _____

Employer's Name _____

Injury Date _____

Claim Number _____

I understand that under the Mississippi Workers' Compensation Law I have the right to choose one physician to render treatment to me. I can either accept the physician to whom I am sent to by my employer or choose someone else on my own.

I also understand that any referral to any other doctor must be made by my one chosen physician.

I also understand that my employer (or workers' compensation carrier) must approve any physician change, and if I change doctors without their authorization, I will be responsible for the medical expense for the unauthorized treatment.

With that understanding I state as follows:

☐ I accept as my choice of physician my employer's tender of treatment by

Dr. _____.

☐ I elect to choose my own physician to render treatment, and that choice is

Dr. _____.

_____
Claimant's Signature

_____
Date

Witnessed by:

_____

_____

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

(IN COMPLIANCE WITH THE HIPPA PRIVACY RULE)

To: _____

For informational purposes pertaining to an insurance claim, I authorize and request the Custodian of Records at the above named entity to disclose to the agents or designees of **Cannon Cochran Management Services (CCMSI)**, any and all records containing ***Protected Health Information (PHI)*** regarding:

_____, DOB: _____, and SS#: _____

whether created before or after the date of signature. This authorization should also be construed to permit agents or designees of **Cannon Cochran Management Services (CCMSI),** to copy, inspect and review any and all such records. Records containing ***PHI*** may include, but are not limited to:

> All medical records, physician's records, surgeon's records, x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films, pathology materials, slides, tissues, physicals and histories, laboratory reports, operating room records, discharge summaries, progress notes, patient in take forms, consultations, prescriptions, nurses' notes, birth certificate and other vital statistic records, communicable disease testing and treatment records, correspondence, psychiatric records, psychological records, psycho-therapy notes, prescription records, medication records, orders for medications, therapists' notes, social worker's records, insurance records, consent for treatment, statements of account, itemized bills, invoices and any other papers relating to any examination, diagnosis, treatment, periods of hospitalization, or stays of confinement.

Unless revoked in writing, this authorization shall be valid for one (1) year from the date of signature. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

- The individual signing this authorization may request the entity provide them with both a copy of the authorization and a copy of the protected health information ***PHI*** to be disclosed.
- The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing, except to the extent that the entity has already relied upon this Authorization to disclose protected health information ***PHI.***
- This authorization only applies to protected health information ***PHI*** already disclosed by the above named entities. This information could be re-disclosed by the receiving parties; in such case, the disclosed ***PHI*** will no longer be protected by the ***HIPAA Privacy Rule***.

I have read this Authorization and understand that it will permit the entity identified above to disclose ***Protected Health Information (PHI)*** to **Cannon Cochran Management Services (CCMSI).**

_____ _____

Signature Name *(Please print)*

_____ _____

Date Address

_____

City/State/Zip

WAGE AND EMPLOYMENT INFORMATION

Employee:_____

Date of Alleged Injury:_____

Date Hired:_____

Last Day Worked:_____

Pay Rate: Per Hour _____ Per Day _____ Per Week _____ Per Month _____

Weeks	Week Ending	No. Days	Gross Wages	Weeks	Week Ending	No. Days	Gross Wages
1.				27.			
2.				28.			
3.				29.			
4.				30.			
5.				31.			
6.				32.			
7.				33.			
8.				34.			
9.				35.			
10.				36.			
11.				37.			
12.				38.			
13.				39.			
14.				40.			
15.				41.			
16.				42.			
17.				43.			
18.				44.			
19.				45.			
20.				46.			
21.				47.			
22.				48.			
23.				49.			
24.				50.			
25.				51.			
26.				52.			

I hereby certify that the above is a true and correct account, as taken from our timebooks or payroll records, of the wages paid to the above named employee for the periods indicated.

Date_____

_____
Employer

By:_____

Position:_____

Telephone Number:_____

Return to:
CCMSI
P. O. Box 1378
Ridgeland, MS 39158-1378
Fax: 601-899-0160