



EXPRESS CLAIM SERVICE
LIVINGSTON CO - MCWCF

Reported by: _____ **Date:** _____
Position: _____ **Phone:** () - ext
Date of Injury: _____ **Time of Injury:** _____ **Lost time?** _____ **If yes, Last Day Worked:** _____

Return to Work (RTW) Date: _____
If no RTW date, estimated RTW date: _____ **RTW Date Unknown**

What is their next scheduled days off? _____ **What Shift?** _____
Account #: _____ **Policy Number:** _____

Location: _____
Date of Hire: _____
Employee's Name: _____
Employee's SS#: 000-00-0000 **Employee Number:** _____ **Bargaining Unit:** _____

Employee's Address: _____

Employee's Phone #: (000) 000-0000

Date of Birth: _____ **Gender:** _____
Employee's Occupation: _____ **Employee Dept.:** _____ **Occupation Code:** _____

Injured on Premises? _____ **If no, City/State of Injury Location:** _____
Was injury fatal? _____ **If yes, please give date:** _____

Type of Injury: _____
Body Part: _____ **If Other:** _____

Cause of Injury: _____
Did you direct employee to a medical provider? _____

* **If yes, Provider Name:** _____
Provider Address: _____
Provider Phone: (000) 000-0000 ext _____

* **If no, do you know where they are treating?** _____
Provider Name: _____
Provider Address: _____
Provider Phone: (000) 000-0000 ext _____

When is next scheduled appointment with provider? _____
Date Employer Notified: _____
Notes: _____

EMAIL THIS CLAIM FORM TO: expressclaims@compone.net