COMPONE
ADMINISTRATORS

EXPRESS CLAIM SERVICE
LIVINGSTON CO - MCWCF

Reported by: **Date**:

Position: **Phone**: ( ) - ext

Date of Injury: **Time of Injury**: **Lost time?** **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#: **Employee Number**: **Bargaining Unit**:

Employee's Address:

Employee's Phone #:

Date of Birth: **Gender**:

Employee's Occupation: **Employee Dept.** **Occupation Code:**

Injured on Premises? **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:

*** If no, do you know where they are treating?**
Provider Name:
Provider Address:

Provider Phone:

When is next scheduled appointment with provider?

Date Employer Notified:

Notes:

EMAIL THIS CLAIM FORM TO: sbono@livgov.com

Rev. 01/31/17