INITIAL CLAIM REPORTING FORM

DATE: _____

TPA: _____

EMPLOYER: _____

EMPLOYEE: _____

FILE #: _____

TPA FILE #: _____

D/A: _____

POLICY #: _____

POLICY PERIOD: _____

SIR: $ _____

RESERVES:

	Indemnity	Medical	Legal	Other	Totals
Paid to Date:	**$**	**$**	**$**	**$**	**$**
Outstanding:	**$**	**$**	**$**	**$**	**$**
Total Incurred:	**$**	**$**	**$**	**$**	**$**

EMPLOYEE INFORMATION:

Occupation:	**Date of Birth**:
Date of Hire:	**Average Weekly Wage $**
Marital Status:	**Comp Rate: $**
Number of Dependents:	**Benefit Type (TT, TP etc)**
Any Offset Amounts (Y/N):	**Modified Work Available?**

Body Part	Description of Injury	Medicare Eligible?
Loss Facts		
Compensability Issues		
Injury Damages		
Subrogation & Second Injury Fund Information		

Litigation Status & Defense Position
Medical Information
Medical Case Management or Attendant Care Services Information
Action Plan