Commonwealth of Massachusetts
Human Resources Division

Workers' Compensation Unit
One Ashburton Place, 3rd Floor
Boston, MA 02108

NOTICE OF INJURY/ILLNESS REPORT

This form is intended for internal use for all Human Resources Division/Workers' Compensation Unit user agencies and must be completed in its entirety. All Notice of Injury Reports must be electronically filed via eServices within 48 hours of an Industrial Accident.

Soc. Sec. #: _____ Date of Injury/Illness: _____

Department: _____

Department mailing address: _____

_____

Name: _____
(First) (Middle) (Last)

Sex: ☐Male ☐Female Employee ID#:_____ Record#:_____

Employee Home Address: _____ City:_____ State:_____ Zip:_____

Home Telephone: _____ Date of Birth _____

Unit: _____

Native Language Code: ☐1. English ☐2. Portuguese ☐3. Haitian Creole ☐4. Spanish
☐5. Chinese ☐6. Vietnamese ☐7. Cape Verdean ☐9. Other

State Hire Date: _____ Department Hire Date: _____

Status: ☐Full Time Employee ☐Part Time Employee Work Hours/Wk:_____

Shift: ☐1st ☐2nd ☐3rd Number of scheduled days off per week:_____

Occupation: (Official Position Title)_____

Functional Title: _____

Payroll Funding Source: ☐ State Payroll ☐Trust Funded ☐Federal Funded

Job Code: _____ Position Type: _____ Position #: _____ Union Code: _____

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Time of event: _____am/pm Date Reported: _____

Time work began on day of event: _____am/pm

Event occurred: ☐Before ☐During ☐After Work shift

What was employee doing just before the event occurred, d*escribe the activity as well as any tools, equipment or material the employee was using. Be specific. Examples:*

1. Walking down the hallway carrying supplies.
2. Restraining a patient.
3. Pouring cleaning solution into a bucket in order to wash the floor.

_____

_____

_____

Third Party Claim: ☐Yes ☐No

How did the injury or illness occur: *Example:*

1. Employee tripped over an electrical cord and fell to the floor
2. Patient was flailing and hit the employee
3. Cleaning solution splashed while being poured.

_____

_____

_____

_____

What was the source of the injury or illness? *Source means the object or substance that directly harmed the employee. What object or substance directly harmed the employee?" Example:*

1. The floor
2. A patient
3. Cleaning solution

_____

_____

_____

_____

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Nature of Injury or illness: *Describe the Nature of the injury.* Example:

1. strained back
2. contusion
3. disorders of the eye

_____

Body part(s) affected, a n*arrative of body parts affected.* Example:

1. low back
2. face, arm
3. eyes

_____

Injury/Illness detail (Choose Only from the Attached List):

Select Body Part:_____

Select Injury/illness:_____

Select One or More Event Categories:

☐ Fall	☐ Lifting	☐ MVA (Motor Vehicle Accident)
☐ Assault	☐ Exposure to Harmful Substances	☐ Repetitive Use
☐ Equipment	☐ Moving/Walking	☐ Stress/Heart Attack
☐ Burn	☐ Cut	☐ Restraint
☐ Other _____	☐ Needlestick/Bloodborne Pathogen Exposure	

Severity of Injury or Illness:

___(1)Minor injury; no likely lost time; no likely medical bills
___(2)Small injury; no likely lost time; possible medical bills
___(3)Moderate injury; possible lost time; probable medical bills
___(4)Significant injury; probably 0 to 5 days of lost time and medical bills
___(5)Severe injury; probably 5 plus days lost time and medical bills

Where The Injury Occurred:

Building: _____

Injury/Illness Location: _____

Was the event the result of a violent act? ☐ Yes ☐ No

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Was the employee engaging in usual job activities: ☐ Yes ☐ No

If no, explain:_____

_____

Injury reported to:_____

Did the injured/ill worker:

a. Lose consciousness? ☐ Yes ☐ No

b. Require medical treatment more than first aid? ☐ Yes ☐ No

c. Have an injury from a contaminated needlestick or other sharp device? ☐ Yes ☐ No

d. Have a significant work-related injury/illness diagnosed by a health care professional? ☐ Yes ☐ No

e. Require transfer to another job or modified duty? ☐ Yes ☐ No

If employee died as a result of injury/illness, what was the date of death? _____/_____/_____

Supervisor: Are you satisfied that the injury occurred as stated? ☐ Yes ☐ No

If no, explain: _____

_____

Manager: Are you satisfied that the injury occurred as stated? ☐ Yes ☐ No

If no, explain: _____

_____

Was the event witnessed? ☐ Yes ☐ No

If Yes, provide the names of witnesses and ask that each prepare a witness statement in their own handwriting and fax those statements to your claims adjuster.

Witness: Name_____ Title_____Tel_____

Name_____ Title_____Tel_____

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Did the employee seek medical attention? ☐ Yes ☐ No

If so, where?

a. Facility: _____

b. Street: _____

c. Town: _____

d. Zip Code: _____

Did the employee seek medical attention away from the worksite? ☐ Yes ☐ No

Was employee treated in an emergency room? ☐ Yes ☐ No

Was employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

Is employee a disabled veteran or has any other known disability? ☐ Yes ☐ No ☐ Unknown

Do you feel the employee would benefit from any referral to Rehabilitation? ☐ Yes ☐ No ☐ Unknown

Do you feel the claim warrants further investigation? ☐ Yes ☐ No

Please attach any information you feel would be useful to HRDWC Unit in managing this claim.

** Please send the employees job description to your HRD Adjuster **

Signature_____ Date:_____

Position:_____

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Attachment for Body Parts and Injuries

Body Parts		
Head	Hip/Buttocks/Groin (Buttocks)	**Upper Extremities**
Brain	Hip/Buttocks/Groin (Groin)	Arm(s), unspecified (Left)
Ear(s), unspecified	Hip/Buttocks/Groin (Hips)	Arm(s), unspecified (Right)
Ear(s), external	Shoulder(s) (Left)	Arm(s), unspecified (Both)
Ear(s), internal	Shoulder(s) (Right)	Arm(s), unspecified (Armpit)
Eye(s) (Left)	Shoulder(s) (Both)	Arm(s), upper (Left)
Eye(s) (Right)	Trunk, Multiple	Arm(s), upper (Right)
Eye(s) (Both)	**Lower Extremities**	Arm(s), upper (Both)
Face, unspecified	Leg(s), unspecified (Left)	Elbow(s) (Left)
Jaw, Chin	Leg(s), unspecified (Right)	Elbow(s) (Right)
Mouth & Throat (Lips)	Leg(s), unspecified (Both)	Elbow(s) (Both)
Mouth & Throat (Multiple)	Knee(s) (Left)	Arm(s), lower (forearm) (Left)
Mouth & Throat (Tongue)	Knee(s) (Right)	Arm(s), lower (forearm) (Right)
Mouth & Throat (Tooth/teeth)	Knee(s) (Both)	Arm(s), lower (forearm) (Both)
Mouth & Throat (Unspecified)	Leg(s), lower (e.g. calf, shin) (Left)	Arm(s), multiple (Left)
Mouth & Throat (Internal (e.g. vocal cords, larynx))	Leg(s), lower (e.g. calf, shin) (Right)	Arm(s), multiple (Right)
Nose	Leg(s), lower (e.g. calf, shin) (Both)	Arm(s), multiple (Both)
Face, multiple	Leg(s), multiple (Left)	Wrist(s) (Left)
Face (Cheeks)	Leg(s), multiple (Right)	Wrist(s) (Right)
Face (Forehead)	Leg(s), multiple (Both)	Wrist(s) (Both)
Scalp	Leg(s), upper (e.g. thigh, hamstring) (Left)	Hand(s), not wrist/fingers (Left)
Skull	Leg(s), upper (e.g. thigh, hamstring) (Right)	Hand(s), not wrist/fingers (Right)
Head, Multiple	Leg(s), upper (e.g. thigh, hamstring) (Both)	Hand(s), not wrist/fingers (Both)
Head	Ankle (Left)	Finger(s)
Neck	Ankle (Right)	Upper Extremities, multiple (Left)
Neck & cervical vertebrae	Ankle (Both)	Upper Extremities, multiple (Right)
Trunk	Foot or Feet, except ankle/toe (Left)	Upper Extremities, multiple (Both)
Trunk, UNS	Foot or Feet, except ankle/toe (Right)	**Other**
Abdomen, internal organs/hernia	Foot or Feet, except ankle/toe (Both)	Other (Body system)
Back	Toe(s)	Other (Multiple body parts)
Chest/Breastbone (Internal organs)	Lower Extremities, multiple (Left)	Non-Classifiable
Chest/Breastbone (Ribs, breastbone)	Lower Extremities, multiple (Right)	
	Lower Extremities, multiple (Both)	

Injuries	
Acute Injuries	**Mental disorders**
Amputation, enucleation	Mental disorders (Anxiety attacks)
Asphyxia, suffocation	Mental disorders (Other mental disorder or syndrome)
Burn, heat	Mental disorders (Stress)
Burn, chemical	**Other Work-related diseases/disorders**
Concussion	Other occupational disease
Contusion, crushing, bruise	Diseases of central nervous system
Cut, laceration, puncture (Except needlestick injury)	Diseases of peripheral nerves and ganglia
Cut, laceration, puncture (Needlestick/sharp injury)	Disease of the blood and blood forming organs
Cut, laceration, puncture (Splinter, chip (foreign body))	Disease of the gastro-intestinal tract
Dislocation	Carpal tunnel syndrome
Fracture	**Poisoning and toxic effects**
Effects of exposure to low temperature	Other poisoning due to toxic materials
Effects of environmental heat	Effects of lead
Hernia, rupture	**Respiratory conditions**
Effects of radiation	Other respatory condition
Scratches, abrasion	Upper respiratory condition (e.g. allergic rhinitis)
Sprains, strains	Asthma
Multiple injuries	Asbestosis
Effects of atmospheric pressure	Silicosis
Bite/Burn/Other Injury (Bite, animal)	Influenza/Pneumonia (Influenza)
Bite/Burn/Other Injury (Bite, human)	Influenza/Pneumonia (Pneumonia)
Bite/Burn/Other Injury (Bite, insect)	**Skin conditions**
Bite/Burn/Other Injury (Burn, other)	Dermatitis
Bite/Burn/Other Injury (Other injury)	Infections of the skin
Electric shock/electrocution	Other skin conditions
Heart/Circulatory System Conditions	**Tumor, cancer**
Heart/Circulatory System (Heart condition/attack)	Tumor, unspecified
Heart/Circulatory System (High blood pressure)	Malignant Tumor
Heart/Circulatory System (Stroke or other circulatory condition)	Benign Tumor
Hearing and eye disorders	**Symptoms, ill defined conditions**
Hearing loss or impairment	Symptoms, ill defined conditions (Back pain, hurt back)
Conjunctivitis	Symptoms, ill defined conditions (Chest pains)
Other diseases of the eye	Symptoms, ill defined conditions (Dizziness)
Infectious or parasitic diseases	Symptoms, ill defined conditions (Headaches, migraine)
Tetanus	Symptoms, ill defined conditions (Nausea, vomiting)
Tuberculosis	Symptoms, ill defined conditions (Pain/Soreness, except back or chest)
Infectious/Parasasitic Diseases (Lyme disease)	Symptoms, ill defined conditions (Sick building syndrome)
Infectious/Parasasitic Diseases (Other infectious or parasitic diseases)	Symptoms, ill defined conditions (Other symptoms and ill defined conditions)
Hepatitis - viral	**Other**
Inflammation of the joints or tendons	No injury or illness
Joint Inflammation, etc. (Arthritis)	Damage to prosthetic devices
Joint Inflammation, etc. (Bursitis)	Non-classifiable (Exposure to saliva/body fluids)
Joint Inflammation, etc. (Other Inflammation of the joints)	Non-classifiable (Non-classifiable)
Joint Inflammation, etc. (Sciatica)	Complications peculiar to medical care
Joint Inflammation, etc. (Tendonitis)	

Workers' Compensation Temporary Prescription ID Card

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer). Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at **(800) 945-5951**.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitation is $150.00, or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at **(888) 786-9640**.

Pharmacy Processing Steps

Step 1: Enter bin number 003858
Step 2: Enter processor control A4
Step 3: Enter the group number as it appears above
Step 4: Enter the injured worker's nine-digit ID number
Step 5: Enter the injured worker's first and last name
Step 6: Enter the injured worker's date of injury
(enter in DOI field in the format YYYYMMDD)

Express Scripts

ID #: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____ /_____ /_____
MM/DD/YYYY

Group #: M5AA

Employee Date of Birth: _____ /_____ /_____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare. *Please see other side for a list of participating retail network pharmacies.*

To the Supervisor: Please fill in the information requested for the injured worker.

Employer Name
Commonwealth of Massachusetts

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

EXPRESS SCRIPTS®

Participating Retail Network Pharmacies

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource
Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare Network
Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

To search for participating pharmacies in your area, please use the "Find a Pharmacy" tool located at: http://www.express-scripts.com/services/workerscompensation/

NOTE: This form is not valid in the state of Ohio. For all other states, liability of a workers' compensation claim is not assumed based on the dispensing of medication(s) to a patient.

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